



Women
With
Disabilities
Australia
(WWDA)



ROYAL COMMISSION INTO VIOLENCE, ABUSE, NEGLECT AND EXPLOITATION OF PEOPLE WITH DISABILITY

WWDA SUBMISSION ON SEXUAL AND REPRODUCTIVE RIGHTS OF WOMEN AND GIRLS WITH DISABILITY

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First Nations peoples should be aware that this publication may contain the names and words of people who have passed.

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WWDA acknowledges the traditional owners of the land on which this publication was produced. We acknowledge First Nations people's deep spiritual connection to this land. We extend our respects to community members and Elders past, present and emerging.

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Women With Disabilities Australia (WWDA) has Special Consultative Status with the Economic and Social Council of the United Nations.

Awards

Winner

National Human Rights Award 2001

Winner

National Violence Prevention Award 1999

Winner

Tasmanian Women's Safety Award 2008

Nominee

UNESCO Prize for Digital Empowerment of Persons with Disabilities 2021

Nominee

French Republic's Human Rights Prize 2003

Nominee

UN Millennium Peace Prize for Women 2000

Certificate of Merit

Australian Crime & Violence Prevention Awards 2008

Nominee

National Disability Awards 2017

Finalist

International Zero23 Award, Information and Communication Technologies (ICT)

ACKNOWLEDGEMENT OF VICTIM-SURVIVORS

In presenting this Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (the Disability Royal Commission), WWDA wishes to acknowledge and thank all the disabled women, girls, feminine-identifying and non-binary people who have been, and continue to be, involved with the work of Women with Disabilities Australia (WWDA).

We pay tribute to those WWDA members and allies who are no longer with us, and who fought so hard to not only secure the Disability Royal Commission, but who also spoke out and spoke up about the egregious human rights violations that women and girls with disability experience, and face, in relation to their fundamental sexual and reproductive rights and freedoms.

We dedicate this Submission to all women and girls with disability who have experienced, and continue to experience, discrimination and gender-based violence, including violations of their sexual and reproductive rights and freedoms.

We acknowledge all women and girls with disability who are victim-survivors of all forms of gender-based violence, and particularly acknowledge those who have been subjected to forced and coerced sterilisation, abortion, contraception, and menstrual suppression.

Although we can never take away the pain and trauma of the women and girls affected, we trust that our work will ensure that the Disability Royal Commission will act to guarantee that these gross violations of the human rights of women and girls with disability will never be allowed to occur again.

To our sisters in other countries who are also continuing the fight for the sexual and reproductive rights and freedoms of all disabled women and girls, we hope that our work can contribute in some small way to your efforts.

ABOUT WOMEN WITH DISABILITIES AUSTRALIA (WWDA)

[Women With Disabilities Australia \(WWDA\)](#) Inc is the national Disabled People's Organisation (DPO) and National Women's Alliance (NWA) for women, girls, feminine identifying and non-binary people with disability in Australia. As a DPO and a NWA, WWDA is governed, run, and staffed by and for women, girls, feminine identifying and non-binary people with disability.

WWDA uses the term 'women and girls with disability', on the understanding that this term is inclusive and supportive of, women and girls with disability along with feminine identifying and non-binary people with disability in Australia.

WWDA represents more than 2 million women and girls with disability in Australia, has affiliate organisations and networks of women with disability in most States and Territories, and is recognised nationally and internationally for our leadership in advancing the rights and freedoms of all women and girls with disability. Our organisation operates as a transnational human rights organisation - meaning that our work, and the impact of our work, extends much further than Australia. WWDA's work is grounded in a human-rights based framework which links gender and disability issues to a full range of civil, political, economic, social and cultural rights. All WWDA's work is based on co-design with and participation of our members. WWDA projects are all designed, governed, and implemented by women and girls with disability.

Disabled People's Organisations (DPOs) are recognised around the world, and in international human rights law, as self-determining organisations led by, controlled by, and constituted of, people with disability. DPOs are organisations of people with disability, as opposed to organisations which may represent people with disability. The United Nations Committee on the Rights of Persons with Disabilities has clarified that States should give priority to the views of DPOs when addressing issues related to people with disability. The Committee has further clarified that States should prioritise resources to organisations of people with disability that focus primarily on advocacy for disability rights and, adopt an enabling policy framework favourable to their establishment and sustained operation.¹

ABOUT THE UNIVERSITY OF TECHNOLOGY SYDNEY (UTS) FACULTY OF LAW

The UTS Faculty of Law is a dynamic and innovative law school. Since its commencement in 1977 it has achieved great success for the quality of its legal education and its commitment to practice-oriented learning. In more recent years it has built a strong reputation for research excellence, engagement, and researcher development.

Dr Linda Steele (Associate Professor, Faculty of Law), and co-author of this Submission, is a socio-legal researcher working at the intersections of disability, law and social justice. She has been researching disability law and social issues for over a decade, having previously been a solicitor with the Intellectual Disability Rights Service. Dr Steele's research focuses on the roles of law, human rights and transitional justice in perpetration and redress of violence against disabled people. Dr Steele reflects on how to engage with legal methods (such as litigation, redress schemes, truth commissions and law reform) to work with disabled people to achieve social justice. Dr Steele explores these concerns in a range of contexts including institutionalisation, sterilisation, criminal justice incarceration, restrictive practices, and segregated ('sheltered') employment.

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ACRONYMS

AAT	Administrative Appeals Tribunal
ABS	Australian Bureau of Statistics
ACAT	ACT Civil and Administrative Tribunal
ADE	Australian Disability Enterprises
Aged Care Royal Commission	Royal Commission into Aged Care Quality and Safety
AHRC	Australian Human Rights Commission
ALRC	Australian Law Reform Commission
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
Child Sexual Abuse Royal Commission	Royal Commission into Institutional Responses to Child Sexual Abuse
COAG	Council of Australian Governments
CRC	Convention on the Rights of the Child
CRPD	United Nations Convention on the Rights of Persons with Disabilities
DPO	Disabled People's Organisation
DPO Australia	Disabled People's Organisations Australia
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
Interim Report	Interim Report of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
LARC	Long acting reversible contraception
NCAT	New South Wales Civil and Administrative Tribunal
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDISQSC	NDIS Quality and Safeguarding Commission
NDIS Act	<i>National Disability Insurance Scheme Act 2013 (Cth)</i>
NDIS RP Rules	<i>National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018 (Cth)</i>

NDS	National Disability Strategy
NPM	National Preventive Mechanism
OPCAT	Optional Protocol on the Convention Against Torture
QCAT	Queensland Civil and Administrative Tribunal
PSS	Personal Safety Survey
RACF	Residential Aged Care Facility
Royal Commission	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability
SACAT	South Australian Civil and Administrative Tribunal
SAT	State Administrative Tribunal
Senate Committee	Senate Community Affairs References Committee
Special Rapporteur on Torture	Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
STVP	Stop the Violence Project
TASGAB	Tasmanian Guardianship and Administration Board
UN	United Nations
UN CEDAW Committee	United Nations Committee on the Elimination of Discrimination Against Women
UN CRPD Committee	United Nations Committee on the Rights of Persons with Disabilities
VCAT	Victorian Civil and Administrative Tribunal
Van Boven Principles	Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law
WWDA	Women With Disabilities Australia

PURPOSE AND STRUCTURE OF SUBMISSION

This Submission from Women With Disabilities Australia (WWDA) introduces into the Royal Commission discussion of sexual and reproductive violence against women and girls with disability. This is a topic that has been largely neglected since the Royal Commission commenced in April 2019, exemplified by the fact there is no Issues paper nor calls for submissions on this topic. It is vital that the Royal Commission recognises sexual and reproductive violence as a significant dimension of violence, abuse, neglect and exploitation of people with disability, that it explores sexual and reproductive violence to the same extent as other topics that have occupied the Royal Commission's work since its inception, and that it address realisation of sexual and reproductive rights and justice as part of its exploration of how to promote a more inclusive society for people with disability.

WWDA's core argument in this submission is that women and girls with disability experience sexual and reproductive violence across their lives in relation to menstruation and reproduction, sexual identity and expression, intimate relationships, pregnancy, and parenting. This violence is a violation of human rights and it must be prohibited and redressed. This has been the position of WWDA for a number of years, and we continue to hold this position.

The submission is structured in **seven** major sections and includes two Appendices:

- Section 1:** Outlines our **fifty-one** recommendations on sexual and reproductive rights.
- Section 2:** Provides background to the Royal Commission in relation to sexual and reproductive violence against women and girls with disability.
- Section 3:** Identifies WWDA's key concerns with the Royal Commission's approach to date on sexual and reproductive violence.
- Section 4:** Provides an overview of an international human rights framework for sexual and reproductive rights.
- Section 5:** Offers a set of concepts and principles for understanding and responding to sexual and reproductive violence against women and girls with disability.
- Section 6:** Explores current lived experiences and laws in relation to sexual and reproductive violence against women and girls with disability.
- Section 7:** Outlines a framework for addressing and redressing sexual and reproductive violence, and realising sexual and reproductive justice.
- Appendix 1:** Provides relevant and recent Concluding Comments from UN Treaty Bodies in relation to sexual and reproductive violence.
- Appendix 2:** Provides endnotes.



1 RECOMMENDATIONS

1. RECOMMENDATIONS

Women With Disabilities Australia (WWDA) submits that the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Royal Commission) must approach sexual and reproductive violence as a core dimension of violence against women and girls with disability and as inextricably related to ableism and structural inequality, discrimination and segregation which are entrenched in law and society.

With this in mind, this Submission from WWDA makes a number of recommendations that encompass a range of areas and issues – including justice systems, the National Disability Insurance Scheme (NDIS), and sexual, reproductive and parenting services and resources.

This section outlines WWDA's **fifty-one** recommendations on sexual and reproductive violence in two stages. It first outlines recommendations to Government that the Royal Commission can include in its final report, and then makes a series of recommendations about the direction and focus of the Royal Commission's work leading up to the final report. Sections 4-6 of this Submission provide context to and elaboration on these recommendations.

Recommendations to Government for Inclusion in Final Report

Human Rights

1. That the Royal Commission recommend the Australian Government establish and enact comprehensive, national, judicially enforceable human rights legislation that fully incorporates its international human rights obligations into domestic law.
2. That the Royal Commission recommend the Australian Government withdraw its Interpretive Declarations on the United Nations Convention on the Rights of People With Disabilities (CRPD) including Article 12 [Equal recognition before the law], Article 17 [Protecting the integrity of the person] and Article 18 [Liberty of movement and nationality] and that the Australian Government review and take action to withdraw its Reservations and Interpretative Declarations to the other human rights treaties to which Australia is a party.
3. That the Royal Commission recommend that Australian and State and Territory independent National Preventive Mechanism (NPM) oversight bodies under the *Optional Protocol on the Convention Against Torture (OPCAT)*, categorise group homes, residential aged care facilities (RACFs), closed mental health units, forensic disability units, hospitals, and broader residential facilities for people with disability as 'places of detention' under the OPCAT, and be monitored accordingly.
4. That the Royal Commission recommend Australia fully implements the recommendations from Australia's reviews under the seven human rights treaties to which it is a party.
5. That the Royal Commission recommend the Australian Government recognise, support and strengthen the role of women with disabilities organisations, groups and networks in efforts to fulfil, respect, protect and promote their human rights, and to support and empower women with disability, both individually and collectively, to claim their rights. This includes the need to create an environment conducive to the effective functioning of such organisations, groups and networks, including adequate and sustained resourcing. Inherent in this, is the need for financial and political support to enable the establishment and recurrent funding of a peak DPO for women with disability in each State and Territory.

6. That the Royal Commission recommend the Australian Government ensure that the Australian Disability Strategy (ADS) 2021-2031, develop specific, gendered, data collection measures to monitor and report on, the sexual and reproductive rights violations experienced by people with disability, particularly women and girls with disability.
7. That, consistent with long-standing recommendations from the UN international human rights treaty monitoring bodies, the Royal Commission recommend the Australian Government commission and fund a comprehensive assessment of the situation of women and girls with disability, in order to establish a baseline of disaggregated data and information against which compliance with the UN treaties (to which Australia is a party) and national policy frameworks can be measured and monitored.

First Nations Self-Determination

8. That the Royal Commission recommend the Australian Government commit to ensuring that First Nations women with disability are afforded their fundamental human right to self-determination and have meaningful involvement in decision making, development and evaluation of supports and systems that affect them.
9. That the Royal Commission recommend the Australian Government increase government and non-government funding and support to develop First Nations owned and operated disability services across Australia, including in remote, regional and urban communities and provide further support and resources to existing services.
10. That the Royal Commission recommend the Australian Government in association with State and Territory Governments, as a matter of urgency, work to address the criminalisation, detention and over-incarceration of First Nations women and girls with disability.
11. That the Royal Commission recommend the Australian Government develop with First Nations communities a comprehensive truth and reconciliation system and related reparations scheme which focuses on the ongoing impacts of settler colonialism on First Nations people with disability, including in relation to sexual and reproductive violence.

Inclusive and Non-Violent Legal and Justice Systems

12. That the Royal Commission, consistent with and reflecting multiple and repeated recommendations from the UN international human rights treaty monitoring bodies, recommend the Australian Government as a matter of urgency enact national, uniform and legally enforceable legislation prohibiting the sterilisation of children, and the sterilisation of adults with disability in the absence of their prior fully informed and free consent.
13. That the Royal Commission recommend the Australian Government in association with State and Territory Governments, as a matter of urgency, prohibit all forms of forced treatment and restrictive practices on and against all people with disability, including forced sterilisation, forced contraception, menstrual suppression and forced and coerced abortion. To commence this work, and in consultation with people with disability, the Australian Government must conduct a comprehensive audit of laws, policies and administrative arrangements underpinning forced treatment and restrictive practices with a view to: introducing reforms to repeal laws and prohibit practices that relate to forced treatment

and restrictive practices. This audit should extend to guardianship laws, family and child protection laws, mental health laws and common law *parens patriae* doctrine.

14. That the Royal Commission recommend the Australian Government establish a nationally consistent supported decision-making framework, that strongly and positively promotes and supports people with disability to effectively assert and exercise their legal capacity and enshrines the primacy of supported decision-making mechanisms, including the right of women and girls with disability to make free, informed and responsible choices about their bodies, sexual health, reproductive health, intimate and emotional relationships, and parenting. This framework must replace (rather than complement) substitute decision-making (such as guardianship frameworks) and as such all substitute decision-making laws and regimes must be abolished.
15. That the Royal Commission recommend State and Territory Governments, as a matter of urgency, repeal substitute decision-making laws, including guardianship law and mental health law, and legislate to limit the scope of the common law *parens patriae* doctrine so it does not apply to people with disability.
16. That the Royal Commission recommend the Australian Government and State and Territory Governments move to eliminate use of substituted decision-making in court and tribunal proceedings (such as guardian ad litem and tutors), including for parents with disability in child protection proceedings, and introduce supported decision-making in justice systems and provide access to associated supports and resources for people with disability to fully participate in court proceedings.
17. That the Royal Commission recommend State and Territory Governments ensure that women and girls with disability are able to safely and inclusively report gender-based violence, have their complaints investigated and prosecuted, and seek civil remedies, including through reforming criminal and civil court procedure laws and evidence laws, and police procedure policies.
18. That the Royal Commission recommend the Australian Government ensure that women and girls with disability are able to access domestic violence legal protections, including through reforming domestic violence legislation to expand the definition of domestic violence and the relationships and residential spaces in relation to which domestic violence is recognised.
19. That the Royal Commission recommend the Australian Government establish a national, accessible, oversight, complaint and redress mechanism for all people with disability who have experienced violence, abuse, exploitation and neglect (including sexual and reproductive violence) irrespective of the setting in which they occurred and when they occurred. This mechanism should be capable of redressing sexual and reproductive violence (both historical and contemporary violations), including measures for victim-survivors of reparation, satisfaction and guarantees of non-repetition as well as compensation, rehabilitation and recovery, as well as structural and community-based redress such as apologies, memorialisation and community education.
20. That the Royal Commission recommend the Australian Government deliver mandated awareness raising among and targeted education of, all actors in the justice system (including for eg: police, judges, lawyers, court officials, prison staff) on the sexual and reproductive rights of women and girls with disability.
21. That the Royal Commission recommend the Australian Government in association with State and Territory Governments commission a national inquiry into ableism (including

gendered ableism), discrimination and segregation experienced by women and girls with disability in Australian legal and justice systems.

22. That the Royal Commission recommend that courts and tribunals exercising the *parens patriae* jurisdiction, including state and territory Supreme Courts, guardianship tribunals and mental health tribunals be subject to greater levels of public transparency and accountability on their hearings and decisions on **all** forms of forced treatment and restrictive practices on and against all people with disability, including forced sterilisation, forced contraception, menstrual suppression and forced and coerced abortion, including through public access to their decisions and quantitative data.
23. That the Royal Commission recommend the Australian Government in consultation with women with disability and their representative organisations commission a national inquiry into the attitudinal, legal, policy and social support environments that give rise to removal of babies and children from parents with disability (including First Nations parents with disability), at a rate at 10 times higher than non-disabled parents.

National Disability Insurance Scheme

24. That the Royal Commission recommend the Australian Government revise the National Disability Insurance Scheme (NDIS) (Supports for Participants) Rules 2013 and related implementation frameworks and strategies to ensure explicit provisions for NDIS participants to access funded supports that enable them to realise their rights to sexual health information, sexual pleasure, expression, association, freedom, autonomy and self-determination, and to make their own choices about how they regulate (if at all) their menstruation and fertility.
25. That the Royal Commission recommend the Australian Government revise the National Disability Insurance Scheme (NDIS) (Supports for Participants) Rules 2013 and related implementation frameworks and strategies to ensure explicit provisions for NDIS participants to access funded supports for their parenting, including at the prenatal stage. Funded supports should be available to parents with disability regardless of whether their children are currently in their care, and should be available to parents who are involved with child protection services or are currently involved in or preparing to be involved in a child protection court matter.
26. That the Royal Commission recommend the Australian Government amend NDIS legislation and policies to prohibit NDIS funding or registration of any services that use any form of forced treatment and restrictive practices on and against people with disability, including forced sterilisation, forced contraception, menstrual suppression and forced and coerced abortion. In the interim, the Australian Government should act to require the National Disability Insurance Scheme (NDIS) Quality & Safeguards Commission, to recognise that forced sterilisation, forced contraception, menstrual suppression and forced and coerced abortion are clear forms of restrictive practices, and that the Commission must address these practices as unauthorised restrictive practices.

Sexual, Reproductive and Parenting Services and Resources

27. That the Royal Commission recommend the Australian Government prioritise, in consultation with women with disability and their representative organisations, the development of accessible and appropriate information resources and materials on the

sexual and reproductive health and rights of women and girls with disability, including on violence against women and girls with disability – for women with disability themselves; frontline workers and other professionals; family, support persons, advocates, friends; and the broader community.

28. That the Royal Commission recommend the Australian Government, in consultation with women with disability and their representative organisations, develop a national strategy to improve access for women and girls with disability to mainstream sexual and reproductive health care on an equal basis with others.
29. That the Royal Commission recommend the Australian Government, in consultation with people with disability and their representative organisations, develop a national strategy to improve access to, and implementation of comprehensive, equitable, accessible, and disability-inclusive sexual and reproductive health education and information, with a particular focus on improving the access to such information for women and girls with disability, regardless of the setting in which they work, live or study.
30. That the Royal Commission recommend the Australian Government, as part of educational curricula, develop a comprehensive suite of educational programs and delivered across the life span, with the aim of:
 - (a) Fostering and valuing diversity and inclusion;
 - (b) Challenging ableism and intersecting forms of inequality and discrimination, including for women and girls with disability;
 - (c) Building knowledge, skills and strengths in recognising rights to bodily integrity and to be free from violence, abuse, neglect and exploitation;
 - (d) Increasing opportunities and participation in decision-making and in speaking up about rights.
31. That the Royal Commission recommend the Australian Government act to ensure that women with disability and LGBTIQ+ people with disability have equal access to assisted reproductive technologies. This must include the requirement for reform of relevant legislation and policies to ensure that single women with disability and sex-same couples are covered by Medicare (and/or their private health insurance) when accessing assisted reproductive technologies.
32. That the Royal Commission recommend the Australian Government establish comprehensive, intensive gender and culturally specific parenting and family support measures for parents with disability, to assist with maintaining children with their parents and within their own family homes. These measures should apply to parents with disability regardless of whether their children are currently in their care.
33. That the Royal Commission recommend the Australian Government require and enforce mandatory disability access policies for all reproductive and sexual health services, including hospitals, GP surgeries, sexual health clinics, women's health services, community health centres etc.
34. That the Royal Commission recommend the Australian Government make available mobile, accessible, and culturally appropriate breast and cervical cancer screening services to all women and girls with disability, including those in all forms of institutional and segregated settings and in regional, rural and remote geographic locations.

35. That the Royal Commission recommend the Australian Government introduce sexual and reproductive health education curriculum at all levels that is inclusive of the sexual and reproductive health and rights of women and girls with disability.
36. That the Royal Commission recommend the Australian Government develop and implement specific, tailored resource materials and training needs for parents, (and families, carers/guardians, etc) regarding the sexual and reproductive health and rights of girls with disability.

Deinstitutionalisation and Desegregation

37. That the Royal Commission recommend the Australian Government pursue the actions identified by DPO Australia in its position paper 'Segregation of People with Disability is Discrimination and Must End'² and adopt the principles in that position paper in order to guide its disability policy and service provision more broadly.
38. That the Royal Commission recommend that the Australian Government develop and implement a national, time bound Deinstitutionalisation and Disability Housing Strategy aimed at closing institutional living arrangements for people with disability; preventing the building of new institutional living arrangements, including the building of new group homes through NDIS Specialist Disability Accommodation (SDA); repurposing existing group homes into genuine community-based housing options; providing resources to increase the supply and range of accessible social and public housing stock; and amending the National Construction Code to mandate minimum universal accessible housing design standards for all new and extensively modified housing. This strategy should provide the necessary housing, supports and resources for people with disability to move to genuine community based housing and have access to individualised, tailored support options that will support inclusion and participation in the general community, including in relation to their sexual and reproductive health and rights.
39. That the Royal Commission recommend that the Australian Government develop and implement a national, time bound Action Plan for Inclusive Education which includes specific strategies for people with disability to realise sexual and reproductive rights.

Data Collection and Research

40. That the Royal Commission recommend the Australian Government commission and fund a three year national research study (in co-design with disabled women and girls) on women and girls with disabilities' right to sexual and reproductive health and freedoms which:
 - (a) investigates models of best practice in the delivery of sexual and reproductive health programs and services for women and girls with disability, including on all matters relating to parenthood and relationships;
 - (b) investigates the practices of forced contraception, menstrual suppression, and forced and coerced abortion of girls and women with disability, including those living in group homes and institutions and institution-like settings. This research must include:
 - investigation into the non-consensual and coerced administration of Depo-Provera and other injectable contraceptives, the contraceptive pill, and other

forms of contraception, (including LARC's) to women and girls with disability;

- investigation into the use of forced contraception, forced sterilisation, menstrual suppression and forced and coerced abortion as forms of social control of women and girls with disability;
- investigation into the effects, including the long term physical, psychological, and social effects of forced contraception, forced sterilisation, menstrual suppression and forced and coerced abortion practices.

41. That the Royal Commission recommend the Australian Government, in consultation with women with disability and their allies, commission specific work to assist women and girls with disability, their families, friends and support persons to access appropriate, accessible and affordable reproductive health services and care. Work in this area would need to include:
- (a) Researching and implementing the specific supports required by families, carers and support persons to better assist them in understanding and managing the menstruation and reproductive health rights and needs of women and girls with disability;
 - (b) Investigating the feasibility of establishing a national scheme (similar to schemes such as the continence aids Payment Scheme), which provides funding for all women and girls with disability and their families, carers and support persons to access appropriate, accessible and affordable reproductive health services and care;
 - (c) Developing national reproductive and sexual health protocols for women and girls with disability that incorporate options for menstrual management and contraception.
42. That the Royal Commission recommend the Australian Government establish, and recurrently fund a National Resource Centre for Parents with Disability, focusing on pregnancy and birthing, adoption, custody, assisted reproduction, adaptive baby-care equipment, as well as general parenting matters. In establishing such a resource centre, the Australian Government should examine similar centres available in other countries, such as the US organisation, Through the Looking Glass.³

Recommendations for the Royal Commission's Work

43. That the Royal Commission conduct a stand-alone Public Hearing on Sexual and Reproductive Rights of People with Disability.
44. That the Royal Commission integrate exploration of sexual and reproductive violence throughout its work, including specific issues papers, hearings and research reports on sexual and reproductive violence, as well as in all of its other work.
45. That the Royal Commission examine the nature, effects and impacts of sexual and reproductive violence on women and girls with disability, including seeking evidence directly from women and girls with disability.
46. That the Royal Commission explicitly recognises sexual and reproductive violence as violating fundamental human rights, including the CRPD and other human rights treaties to

which Australia is a party, and as a form of structural discrimination.

47. That the Royal Commission explore historical and contemporary sexual and reproductive violence, and that it explore ongoing connections across time of sexual and reproductive violence to settler colonialism and eugenics, and the contemporary connections of this violence to neoliberalism.
48. That the Royal Commission's definition and exploration of restrictive practices extends to forms of restriction that apply only or primarily to women and girls with disability, including non-consensual and coercive sterilisation, contraception, menstrual suppression and abortion.
49. That the Royal Commission explores the role of legal and justice systems in sexual and reproductive violence against women and girls with disability. As part of this work, the Royal Commission should specifically consider: ableism (including gendered ableism), discrimination and segregation within legal doctrine, justice systems, the judiciary and the legal profession, barriers to accessing police, criminal and civil justice systems, and the role of legal doctrine, justice systems, the judiciary and the legal profession in facilitating perpetration of sexual and reproductive violence against women and girls with disability (including in the contexts of guardianship law, mental health law, and the common law *parens patriae* doctrine).
50. That the Royal Commission consider redress for sexual and reproductive violence (both historical and contemporary violations), including measures for victim-survivors of reparation, satisfaction and guarantees of non-repetition as well as compensation, rehabilitation and recovery, as well as structural and community-based redress such as apologies, memorialisation and community education.
51. That the Royal Commission, in all areas of its work, explicitly recognise and conceptualise the segregation of people with disability as discrimination, that segregation is an underpinning enabler of violence, abuse, neglect and exploitation, that segregation constitutes systemic violence, abuse, neglect and exploitation; and the Disability Royal Commission must hold governments and other stakeholders to account for supporting, maintaining and funding segregated legal, justice, service, residential, educational, employment and other systems.



2 BACKGROUND TO THE ROYAL COMMISSION AND WWDA'S SUBMISSION

2. BACKGROUND TO THE ROYAL COMMISSION AND WWDA'S SUBMISSION

- 2.1 This section provides background to the Royal Commission in relation to sexual and reproductive violence against women and girls with disability.
- 2.2 WWDA's Submission focuses on sexual and reproductive violence in relation to women and girls with disability as part of a broader issue of realising sexual and reproductive rights and justice. **We use the term 'women and girls with disability' on the understanding that this is inclusive of women, girls, feminine identifying and non-binary people with disability in Australia.**
- 2.3 WWDA welcomes the opportunity to make this Submission to the Royal Commission. We request that the DRC reads this Submission in association with WWDA's earlier submissions, notably the *WWDA Submission on Rights and Attitudes* and the *WWDA Submission on Restrictive Practices*; and the *WWDA Submission 'Towards Reproductive Justice for young women, girls, feminine identifying, and non-binary people with disability (YWGwD): Report from the YWGwD National Survey,'* published in November 2022.

WWDA Position on Sexual and Reproductive Rights

- 2.4 Sexual and reproductive rights is a core aspect of WWDA's work, and WWDA has a clear and longstanding position on this issue.⁴ WWDA's position informs this Submission, and we set out key aspects here.
- 2.5 WWDA believes that women and girls with disability have the right to sexual pleasure, expression, association, equity, privacy, freedom, autonomy and self-determination.
- 2.6 WWDA believes women and girls with disability have the right to make free and informed choices about their bodies, sexual health, reproductive health, intimate and emotional relationships, and parenting.
- 2.7 WWDA believes that recognising sexual and reproductive rights encompasses the basic right of all couples and individuals to found and maintain a family, including the right to decide freely and responsibly the number, spacing and timing of their children and to have access to the information and means to do so.
- 2.8 WWDA believes that forced sterilisation,⁵ forced abortion, forced contraception and menstrual suppression constitute egregious forms of reproductive violence against women and girls with disability and are violations of the right to freedom from torture and other cruel, inhuman, or degrading treatment or punishment.
- 2.9 WWDA believes the denial of sexual and reproductive rights to women and girls with disability, especially forced and coerced sterilisation and the forced removal of children on the basis of a mother's disability, constitute egregious violations of fundamental human rights.
- 2.10 WWDA is unequivocal in its position of actively opposing sterilisation of any child, with or without disability and with or without court authorisation, unless the procedure is required, or is a by-product of, a medical life-saving emergency.

- 2.11 WWDA is unequivocal in its position of actively opposing sterilisation of any woman without her full, free, prior and informed consent.
- 2.12 WWDA believes the widespread denial of sexual and reproductive rights is continuing unabated due to deep-rooted inequality and ableism and extreme forms of discrimination against and segregation of women and girls with disability.

The Silence on Sexual and Reproductive Violence Against Women and Girls with Disability

- 2.13 The necessity for the Royal Commission and the high expectations WWDA hold for what it should achieve in relation to sexual and reproductive rights is underscored by the silence on sexual and reproductive violence in relation to past Government inquiries and law reform reviews.
- 2.14 In the Australian context, there have been many Government inquiries and law reform reviews over the past five to 10 years that are relevant to sexual and reproductive violence against women and girls with disability. These fall into two categories: inquiries and law reform reviews that have focused specifically on people with disability and those that have not been focused on people with disability. We will consider each of these in turn, noting the limited extent they have recognised sexual and reproductive violence against women and girls with disability.

Inquiries and Law Reform Reviews Focused on People with Disability

- 2.15 Generally, inquiries and law reform reviews that are focused on people with disability have considered topics that intersect with sexual and reproductive violence, but have not given in-depth consideration to the experiences and needs of women and girls with disability.
- 2.16 In 2013, the Senate Community Affairs References Committee (the Senate Committee) reported on its inquiry into the Involuntary or Coerced Sterilisation of People with Disabilities in Australia. In its report, the Committee observed that sterilisation was being used to manage a broad array of care issues by reason of ‘lack of appropriate and adequate support for both people with disabilities and their carers.’⁶ The Senate Committee made a number of recommendations relating to access to education, training and information around sexuality and relationships for people with disabilities and families, medical and disability workers. It also recommended disability support planning that addressed support for menstruation as well as ‘support for relationships and sex education’.⁷ Yet, the report ultimately fell short of recommending absolute prohibition of forced and coercive sterilisation. Instead, it approached the legality of sterilisation along capacity lines. The Senate Committee maintained the existing division along the lines of capacity and only recommended a *rebuttable presumption* of legal capacity rather than recommending that all people with disability be recognised as having legal capacity.⁸ It recommended that third party consent to sterilisation should be banned only for individuals with capacity to consent (or who will likely develop capacity to consent in the future).⁹ In contrast, those without capacity to consent should continue to have third parties deciding on their behalf but pursuant to a reformed legal test of ‘best protection of rights’ instead of ‘best interests’.¹⁰ The proposed ‘best protection of rights’ test focuses on *particular* human rights, e.g. to health and excludes the right to non-discrimination and equality. While not going so far as to prohibit sterilisation, it did recommend sterilisation not be permissible on certain grounds: *‘The Committee abhors the suggestion that sterilisation ever be used as a means of managing the pregnancy risks associated with sexual abuse and*

strongly recommends that this must never be a factor in approval of sterilisation.¹¹ The Senate Committee did acknowledge submissions on limited legal remedies for unlawful sterilisations, but it did not make any recommendations in relation to redress, even in the context of illegal sterilisation.¹² In its review of Australia in 2013, the United Nations Committee on the Rights of Persons with Disabilities (UN CRPD Committee) stated it was *'deeply concerned that the Senate inquiry report ... puts forward recommendations that would allow this practice [of sterilization] to continue*.'¹³ The UN CRPD Committee urged Australia to adopt laws prohibiting sterilisation *'in the absence of their prior, fully informed and free consent*.'¹⁴

- 2.17 In 2014, the Australian Law Reform Commission (ALRC) in its review *Equality, Capacity and Disability in Commonwealth Laws* recommended a shift from substituted to supported decision-making for people with disability. It recommended the reform of Commonwealth, State and Territory laws consistent with four 'National Decision-Making Principles': equal right to make decisions and have decisions respected; provision of support persons for decision-making; supported decision-making must be directed by the will, preferences and rights of individuals; and laws and legal frameworks must contain safeguards to prevent abuse and undue influence in decision-making.¹⁵ It also recommended introduction of the 'Commonwealth decision-making model' which consists of 'supporters' who provide support to an individual to make decisions and 'representatives' who are appointed (as a last resort and in limited circumstances) to make decisions for individuals based on their will and preferences because the individual desires or requires a third party decision-maker.¹⁶ The ALRC recommended that State and Territory Governments review their 'legislation that deals with decision-making to ensure laws are consistent with the National Decision-Making Principles and the Commonwealth decision-making model.'¹⁷ The ALRC recommended the Australian Government and the Council of Australian Governments (COAG) take the 'National Decision-Making Principles' into account in the development of the national quality and safeguards system for NDIS disability services.¹⁸
- 2.18 The ALRC also recommended the 'Australian Government and COAG adopt a similar, national approach to the regulation of restrictive practices in other relevant sectors such as aged care and health care', as exists in the context of the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector which requires States and Territories to reduce the use of restrictive practices.¹⁹ ALRC made recommendations to amend existing marriage laws which make it possible to void a marriage in relation to an individual who is 'mentally incapable': 'Sections 23(1)(iii) and 23B(1)(d)(iii) of the *Marriage Act 1961* (Cth) should be amended to remove the references to 'being mentally incapable' and instead provide that 'real consent' is not given if 'a party did not understand the nature and effect of the marriage ceremony'.²⁰ The ALRC noted submissions that 'persons with disability may experience discrimination or difficulties in exercising their rights to marry and to form intimate relationships' but was of the view that '[w]hile important, many of these issues arise at a state or territory level' and thus were outside the scope of the review. While the ALRC recognised submissions made by some Disabled People's Organisations (DPOs) concerning sterilisation and other forms of gendered violence associated with denial of legal capacity, the ALRC only noted these in the context of its discussion of State and Territory laws²¹ and did not make any recommendations about reform of Commonwealth law, such as Commonwealth Family Law powers to authorise third party consent to sterilisation of children.
- 2.19 In its 2015 final report to its inquiry into Violence, Abuse and Neglect against People with Disability in Institutional and Residential Settings, the Senate Community Affairs References Committee specifically considered violence against women and girls with disability.²² These recommendations were made in the context of the Senate Committee acknowledging high rates of violence against women with disability, and increased risk factors for this group²³ and 'the lack of inclusion of the specific needs of women and children with disability within

mainstream protective frameworks'.²⁴ It formed the view that there was 'a need for the integration of domestic violence programs with disability services to ensure people with disability have access to the same supports' and 'the National Plan should include specific actions to address violence against women and girls in residential settings, including ensuring access to mainstream services and specialist disability services'.²⁵ The Senate Committee made recommendations specifically directed towards addressing violence against women and girls with disability. For example, the 'need for further investigation of access to justice issues' specifically in relation to women with disability,²⁶ updating the National Plan to Reduce Violence against Women and their Children 'to include institutional and disability accommodation settings' and associated 'increased funding to support women with disability escaping domestic violence',²⁷ and improved Australian Bureau of Statistics (ABS) data collection on violence against people with disability, including in relation to gender.²⁸ The Senate Committee considered 'disability-specific interventions', including restrictive practices.²⁹ The Committee expressed agreement with the ALRC's report and its recommendations about supported decision-making.³⁰ It indicated support for the 'implementation of a supported decision-making model that recognises a graduated continuum of legal capacity for people with disability'.³¹ However, the Senate Committee in its chapter on disability-specific interventions did not express any views specifically in relation to the gendered dynamics of restrictive practices or restrictive practices that apply only or primarily to women and girls with disability such as forced and coercive sterilisation, menstrual suppression, contraception and abortion. Moreover, the report did not make any specific recommendations in relation to redress for violence in institutional and residential settings.

- 2.20 In 2018, the Australian Human Rights Commission (AHRC) released a report on safeguarding against violence in institutional settings (including institutional settings in the context of disability, health, mental health, aged care, justice, education, and child protection services).³² AHRC recognised human rights of women with disability, including in relation to forced sterilisation.³³ It recommended quality, safeguarding and oversight mechanisms in the disability and mainstream sectors that take a human rights approach. In noting that restrictive practices violate human rights, the AHRC stated that it is 'important that the use of restrictive practices be eliminated wherever possible, and where they continue to be used they must be effectively regulated'.³⁴ However, the report did not specifically consider sexual and reproductive violence, and its consideration of restrictive practices did not explore those specific to women and girls with disability, such as forced and coercive sterilisation, menstrual suppression, contraception and abortion. Moreover, the report did not make any specific recommendations in relation to redress for violence in institutional settings.
- 2.21 There have also been multiple reviews of State and Territory guardianship³⁵ and mental health laws³⁶ that provide legal frameworks for forced and coercive sterilisation, menstrual suppression, contraception and abortion, and for preventing women with disability from exercising autonomy in relation to intimate relationships and marriage. While many of these reviews have considered the CRPD and have indicated support for working towards some degree of supported decision-making and reduction of restrictive practices, none have gone so far as to recommend the complete prohibition of non-consensual and coercive interventions nor have they made specific reference to prohibition of sterilisation, menstrual suppression, contraception and abortion.
- 2.22 There have been multiple reviews specifically in the context of aged care, yet these have given marginal consideration to sexual violence against women with disability. In 2017, the ALRC released its final report on its inquiry into elder abuse.³⁷ It recommended that an 'independent oversight body should monitor and oversee the approved provider's investigation of, and response to, serious incidents', including sexual abuse³⁸ (defined as 'rape and other unwanted sexual contact', 'inappropriate touching and the use of sexually

offensive language’).³⁹ It also recommended enactment of adult safeguarding laws that ‘should give adult safeguarding agencies the role of safeguarding and supporting ‘at-risk adults’.⁴⁰ In the context of ‘sexual abuse’, the ALRC recommended that ‘adult safeguarding laws should provide that consent is not required prior to safeguarding agencies investigating, or taking any other action’.⁴¹ The ALRC report did not consider the specific incidence of circumstances of sexual violence against women with disability in RACFs. Also, in relation to aged care, in 2019, the Royal Commission into Aged Care Quality and Safety (Aged Care Royal Commission) released its interim report, *Neglect*. This report acknowledged the high number of sexual assaults in RACFs: ‘4013 notifications of alleged or suspected physical and/or sexual assaults in aged care in 2017–18’.⁴² In its final report, the Aged Care Royal Commission recognised the widespread problem of ‘substandard care’ (which can ‘take the form of deliberate acts of harm and forms of abuse—including physical and sexual abuse’)⁴³ and that ‘[a]buse is an extreme example of substandard care and reaches into the realm of criminal behaviour’.⁴⁴ It noted that ‘the number of people who have experienced substandard care is inexcusably high’⁴⁵ and that the ‘estimated number of alleged incidents of unlawful sexual contact in 2018–19 could be as high as 2520, or almost 50 per week’.⁴⁶ The report did not disaggregate the statistics by gender, but did include examples of sexual violence against women.⁴⁷ The Aged Care Royal Commission recommended that the Australian Government should develop ‘a new and expanded serious incident reporting scheme’⁴⁸ which is focused on service improvement and service sanctions.⁴⁹ The Aged Care Royal Commission recommends legislative reform to enable service users to seek compensation through the courts in relation to breach of certain provisions in the proposed new aged care legislation.⁵⁰ There are no recommendations for redress in relation to past experiences of violence, abuse, neglect and exploitation in aged care, including sexual violence.

General Government Inquiries and Law Reform Reviews

- 2.23 Over the past 5-10 years there have been numerous general government inquiries and law reform reviews related to interpersonal violence, including in the contexts of family violence,⁵¹ sexual consent,⁵² and institutional child sexual abuse.⁵³ There have also been general government inquiries and law reform reviews on abortion⁵⁴ and family law,⁵⁵ which are contexts in which sexual and reproductive violence against women and girls with disability occurs. These have largely overlooked the experiences and needs of women and girls with disability that do not fit within the experiences and needs of women without disability. We return to this issue in a more conceptual sense in Section 5, but for present purposes we identify **four** key limitations in the general government inquiries and law reform reviews.
- 2.24 First, some of these inquiries and reviews have failed to give any consideration to women and girls with disability as a specific population group. For example, the May 2020 report from the Senate Legal and Constitutional Affairs References Committee Inquiry on Domestic Violence made only one reference to disability, in the context of a series of questions the Committee suggested be considered in the development of the next iteration of the National Plan to Reduce Violence Against Women and Their Children ((‘e) Is there enough support for women with disabilities?’).⁵⁶ In contrast, some state-based sexual violence law reform reviews have identified women with disability as a specific victim population group, but have not explored the specific dynamics of their experiences of sexual violence,⁵⁷ including dynamics of consent, capacity and control.
- 2.25 Second, these general government inquiries and law reform reviews have not considered forms, contexts and places of violence that are specific to sexual and reproductive violence against women and girls with disability. These forms of violence include forced

and coercive sterilisation, menstrual suppression, contraception and abortion, withholding of medication, income support payments, mobility/accessibility devices or other supports which are central to survival and participation within the community. Contexts of violence include domestic violence which might occur in informal or paid care provision, disability services provision, medical care, and participating in education, employment and transportation (particularly where these services are segregated). Sexual and reproductive violence against women and girls with disability does not only occur in the family home. For women and girls with disability it can additionally occur in group homes, mental health facilities, hospitals, prisons, and aged care facilities, and the other segregated and closed settings in which they live, study and work. The Royal Commission into Institutional Responses to Child Sexual Abuse (Child Sexual Abuse Royal Commission) did explicitly consider children with disability (including girls with disability) as a particular population group, and made recommendations specifically in relation to future abuse prevention in out of home care and disability services.⁵⁸ However, that inquiry was focused on sexual abuse and thus did not extend to the full range of sexual and reproductive violations experienced by girls with disability in institutional settings, notably forced and coercive sterilisation and menstrual suppression. In contrast the Senate Legal and Constitutional Affairs References Committee Inquiry on Domestic Violence, which had a wide remit in its terms of reference to explore various aspects of responses to ‘domestic violence with particular regard to violence against women and their children’,⁵⁹ did not consider the particular forms, contexts and places of domestic violence experienced by women and girls with disability. While the ALRC inquiry into Family Law considered Family Court authorisation of parental consent to sterilisation of girls with disability in its issues paper and discussion paper,⁶⁰ this topic was completely absent from its final report.⁶¹ State-based law reform reviews of abortion law have focused on decriminalisation of consensual abortion in crimes legislation and have not recommended prohibition of forced and/or coerced abortion in relation to women and girls with disability, and indeed some have even affirmed the appropriateness of existing mental health and guardianship laws on non-consensual abortion.⁶² Further, in focusing largely on negative sexual experiences, these state-based inquiries and reviews have not acknowledged as violence the denial of supports and resources for women and girls with disability to experience positive sexual experiences and intimate relationships.

- 2.26 Third, general government inquiries and law reform reviews have not always considered accessibility and support needs of women and girls with disability in terms of responses to violence, including justice and social service system responses to victims of violence and violence prevention strategies. For example, women’s crisis accommodation, sexual health and other support services might not be physically or cognitively accessible or trauma-informed. Structural ableism, physical and cognitive inaccessibility and the absence of trauma-informed approaches in justice systems can prevent women and girls with disability from participating in court and giving evidence, and can even mean they are denied the opportunity to make a report to police and have their matter investigated. An exception to the general absence of consideration of accessibility and support needs is the ALRC’s 2019 Review of Family Law which made recommendations for the introduction of a supported decision-making framework into the *Family Law Act 1975* (Cth) to enhance participation of people with disability in Family Court proceedings.⁶³ The Victorian Law Reform Commission review of improving the response of the justice system to sexual offences identifies people with disability as a specific population with particular experiences and needs in justice systems.⁶⁴ Its final report made recommendations concerning access to intermediaries and independent third persons.⁶⁵ The Child Sexual Abuse Royal Commission recommended funding of support services for people with disability who have experienced child sexual abuse: ‘Australian Government and state and territory governments should fund support services for people with disability who have experienced sexual abuse in childhood as an ongoing, integral part of advocacy and support and therapeutic treatment service system responses for victims and survivors of child sexual abuse’.⁶⁶ Moreover, the Child Sexual Abuse Royal Commission’s recommendations in relation to a redress

scheme recommended that the ‘redress scheme should consider adopting particular communication strategies for people who might be more difficult to reach’, including ‘people with disability’.⁶⁷ Following implementation of the national redress scheme in light of the Child Sexual Abuse Royal Commission recommendations, the Joint Select Committee on Implementation of the National Redress Scheme’s interim report noted DPO concerns with structural barriers for people with disability in accessing the redress scheme.⁶⁸

- 2.27 Fourth, general government inquiries and law reform reviews have not considered implications of the CRPD for conceptualising and responding to violence against women. The ALRC inquiry into family law considered the CRPD in relation to introducing supported decision-making in the Family Court to replace existing practices of substituted decision-making through appointment of litigation guardians.⁶⁹ However, that ALRC inquiry did not consider the CRPD in relation to Family Court authorisation of parental consent to sterilisation of girls with disability and the issue of sterilisation was not even discussed in the final report.

Emerging Law Reform Issues

- 2.28 Exclusion of sexual and reproductive violence against women and girls with disability from conventional understandings of violence against women and girls is further demonstrated by recent activist and policy initiatives:
- (a) Abortion decriminalisation focuses exclusively on reforming crimes legislation that criminalises women for accessing abortion,⁷⁰ while leaving unreformed the *absence of criminalisation* of forced and coercive abortion, contraception and sterilisation of women and girls with disability pursuant to disability-specific law (and, as mentioned earlier some recent abortion law reform reviews have explicitly noted current guardianship laws on abortion are appropriate).
 - (b) Increased attention to obstetric violence as a form of violence against women focuses on violence against women perpetrated in the context of reproductive healthcare,⁷¹ but has not explicitly considered experiences of women and girls with disability, including obstetric medical care that results in sterilisation, abortion, forced contraception or forced removal of children.
 - (c) Law reform inquiries and legislative developments in relation to coercive control⁷² focus on ongoing psychological control in the context of intimate partners but it is unclear whether these laws will extend to particular modes and contexts of control experienced by women and girls with disability. For example, it is not clear if coercive control laws are capable of responding to control of women and girls with disability through restrictive practices, substituted decision-making or in contexts outside of intimate/domestic relationships such as in disability support services or disability residential settings,⁷³ or whether implementation of coercive control laws will be accompanied by strategies to address systemic issues with discriminatory and punitive responses by police to people with disability (particularly people with psychosocial disability, and First Nations peoples).⁷⁴

The Royal Commission

- 2.29 The Royal Commission⁷⁵ was established after many years of campaigning by people with disability and our representative organisations at both the domestic and international level.⁷⁶

- 2.30 WWDA played a leading role in these advocacy efforts, and in particular, in exposing the gendered nature of violence against people with disability.
- 2.31 In 2015, our collective campaign efforts led to establishment of the Senate Inquiry into Violence, Abuse and Neglect Against People with Disability in Institutional and Residential Settings ('the Disability Violence Senate Inquiry').⁷⁷ Recommendation 1 from the Disability Violence Senate Inquiry was that a Royal Commission into violence against people with disability be established.⁷⁸
- 2.32 However, it was not until 2019, following further concerted advocacy efforts that the Royal Commission was finally established by the Australian Government. The urgent need for a Royal Commission into all forms of violence against people with disability was a key recommendation from the 2017 review of Australia's compliance with the International Covenant on Economic, Social and Cultural Rights ('ICESCR'), and was also addressed at the September 2019 review of Australia's compliance with the CRPD.
- 2.33 The Terms of Reference for the Royal Commission are contained in the Commonwealth Letters Patent that were signed by the Governor General on 4 April 2019. The Terms of Reference explicitly state that:
- Australia has international obligations to take appropriate legislative, administrative and other measures to promote the human rights of people with disability, including to protect people with disability from all forms of exploitation, violence and abuse under the Convention on the Rights of Persons with Disabilities.⁷⁹*
- 2.34 The Terms of Reference reflect our campaign calls that the Royal Commission should have regard to 'all forms of violence against, and abuse, neglect and exploitation of, people with disability, whatever the setting or context.'⁸⁰
- 2.35 The Terms of Reference also reflect our calls for recognition of intersectional dimensions of people with disability that make the experiences of violence, abuse, neglect and exploitation specific, unique and diverse:
- ... the specific experiences of violence against, and abuse, neglect and exploitation of, people with disability are multi-layered and influenced by experiences associated with their age, sex, gender, gender identity, sexual orientation, intersex status, ethnic origin or race, including the particular situation of Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people with disability.⁸¹*
- 2.36 An intersectional analysis required by the Terms of Reference and enshrined in the CRPD is critical to ensuring that the Royal Commission identifies, understands and addresses all forms of violence experienced by people with disability and across all settings.

Dearth of Official Data Collection on Sexual and Reproductive Violence Against Women and Girls with Disability

- 2.37 There is a lack of comprehensive data on sexual and reproductive violence against women and girls with disability. Without such data, it is difficult to appreciate the full extent of this violence and thus there is a risk the Royal Commission's definition, exploration and recommendations in relation to sexual and reproductive violence will not respond to the full extent and complexity of this violence.
- 2.38 The dearth of official data collection in the context of sexual and reproductive violence against women and girls with disability has three implications for the purposes of the Royal

Commission's work:

- The Royal Commission must use its powers and resources to quantify sexual and reproductive violence.
- Noting the role of justice systems and government departments in enabling and regulating sexual and reproductive violence against women and girls with disability, this quantification must extend to data collection from courts, tribunals, health departments, disability and aged care regulatory bodies, public guardians, and disability and aged care services.
- Quantification must extend to forced and coercive sterilisation, contraception, menstrual suppression and abortion.

2.39 While the Royal Commission and its commissioned researchers have no control over existing datasets, the Royal Commission could use its powers and resources to quantify violence, abuse, neglect and exploitation in terms of a more expansive approach that includes data on sexual and reproductive violence.

2.40 There is a dearth of official data collection on sexual and reproductive violence against women and girls with disability, notably disaggregated data, research and studies. The Royal Commission Interim Report does discuss available data on unlawful sexual violence,⁸² however there is no available data on other aspects of sexual and reproductive violence. The Interim Report acknowledges limitations in data, relevant for present purposes noting that:

Preventing violence against, and abuse, neglect and exploitation of, people with disability cannot be fully effective until we have better data. As described above:

- *There is no national data on people with disability and their experiences of neglect and exploitation.*
- *The data on children with disability is limited to those in out-of-home care, which is inadequate for understanding children's experiences of violence, abuse, neglect and exploitation.*
- *There is no national data on violence against, and abuse, neglect and exploitation of, people with disability who live in institutions, such as prisons, or who are homeless.*
- *There is no data on First Nations people and their lifetime experiences of violence. There is no data on First Nations people and their experiences of neglect or exploitation. There is no data on First Nations children and their experiences of violence, abuse, neglect and exploitation.*
- *People who do not speak English well – or at all – including those with communication disability are often excluded from national surveys.*
- *There is no data on people with disability who are LGBTIQ+.*
- *There is no data on forms of violence that are specific to people with disability, such as bullying and discrimination, withholding access to medical treatments or medication, and exploiting or denying a person's control over or ownership of their body.*
- *There is no way to tell whether people with disability's experiences of violence and abuse occur commonly and as part of a pattern, as in domestic and family violence, or are one-off events.⁸³*

- 2.41 The absence of data makes it extremely difficult to understand the nature and scope of violence against women and girls with disability, and identify the necessary specific measures for violence prevention, identification, response and redress. This absence also results in women and girls with disability being largely excluded from policies, programs, services and measures to progress gender equality.⁸⁴ Furthermore, there is little to no intersectional analysis, research or disaggregated data that examines the experience of violence, abuse, neglect and exploitation of specific groups of women and girls with disability, such as those who are: First Nations, from culturally and linguistically diverse backgrounds, migrants, refugees or asylum seekers, lesbian, gay, bisexual, transgender or intersex, or living in rural and remote communities.⁸⁵
- 2.42 It is now well established that violence against women and girls with disability globally and in Australia is far more extensive, frequent and significantly more diverse in nature than violence amongst either their male counterparts or women and girls without disability.⁸⁶ A national survey undertaken in 2013 as part of the [then] Council of Australian Governments (COAG) Reform Project 'Stop the Violence' ('STVP') found that violence is present in the lives of approximately twenty-two per cent of women and girls with disability who had accessed service support⁸⁷ in the preceding 12 months. The main types of violence experienced by the women included: domestic violence (80%); emotional abuse (68%); sexual violence and abuse (63%); financial abuse (58%); the withholding of care (23%); and the withholding of medication (14%). Importantly, findings from the survey provided data only on women and girls with disability *who had accessed services*. However, current literature, Australian Government reporting on the service use of people with disability, and reports from family violence services⁸⁸ and women with disability themselves suggest that many women and girls with disability do not and/or cannot and/or are prevented from using and/or accessing services. As highlighted by STVP, it is highly likely that significant numbers of women and girls with disability who are experiencing or at risk of violence do not access any type of service. This suggests that the prevalence of violence against women and girls with disability is likely to be substantially higher than the already alarming 22 per cent suggested by the 2013 STVP national survey findings.
- 2.43 It is widely recognised that any available official data relating to incidence and prevalence of violence against women and girls with disability does not give the true picture of the level of risk and prevalence of violence and abuse due to many factors and barriers to reporting violence that are experienced by women and girls with a disability. Just some of these factors include, for example: the reinforced demand for compliant behaviours; the perceived lack of credibility; social isolation; lack of access to learning environments; lack of awareness of rights and what constitutes violence, abuse, neglect and exploitation; dependence upon others; fear of losing services; lack of access to police, support services, lawyers or advocates; lack of public scrutiny of institutions; and the entrenched sub-culture of violence and abuse prevalent in institutional and/or segregated settings.⁸⁹
- 2.44 Existing data collection on violence against women does not explicitly extend to the forms, contexts, and places of violence experienced by women with disability, and this is particularly so in relation to sexual and reproductive violence. Where it does exist, official data is largely focused within the area of domestic and family violence and conceptualised within a narrow framework and discourse of spousal and/or intimate partner violence.⁹⁰ This narrow focus does not reflect contemporary understandings of what constitutes gender-based violence, nor the complexity of the myriad forms it takes, and the settings in which it occurs in relation to women and girls with disability. As a result, violence against women with disability that occurs in different forms, contexts or places to gender-based violence against non-disabled women is obscured. Women and girls with disability experience marginalisation in, and exclusion from, legislation, policies and service responses designed to address and prevent violence against women.⁹¹ This problem is acknowledged by the Royal Commission in its Interim Report, when it states:

*'This absence of data means that nobody can estimate with confidence the levels of violence, abuse, neglect and exploitation experienced by people with disability. This makes it difficult for governments and other agencies with policy-making responsibilities to design and implement effective policies and programs.'*⁹²

2.45 While research studies over the past decade have begun to focus on violence experienced by women and girls with disability, the focus of these studies has largely been on the incidence and experiences of women with disability in the area of domestic and family violence.⁹³ For example, the ABS *Personal Safety Survey* (PSS) is the key Australian data asset that collects information on the nature and extent of violence experienced by men and women aged 18 years and over.⁹⁴ The 2016 PSS found that women with disability were more likely to have experienced violence in the preceding 12 months than women without disability.⁹⁵ However, the PSS's sampling frame includes only people living in private dwellings and excludes residential care and institutional facilities, such as group homes. WWDA is not aware of *any* statistical collections, where the Commonwealth is a data custodian, which specifically collects data on experiences of violence for women and girls living in non-private dwellings, or segregated environments/settings such as Australian Disability Enterprises (ADEs), or other forms of institutional and congregate care settings. The Disability Royal Commission has acknowledged the limitations of the PSS in its Interim Report.⁹⁶ Following its review of Australia in 2019, the UN CRPD Committee expressed its concern regarding the 'limited data collection instruments on violence against women and girls with disabilities' and recommended that the Australian Government 'address the methodological restrictions in data collection instruments used to capture data on violence against women and girls with disability.' The CRPD Committee also strongly urged Australia to 'develop a national disability data framework to ensure appropriate, nationally consistent measures for the collection and public reporting of disaggregated data across the full range of obligations contained in the Convention, especially with regard to women, children and Indigenous persons with disabilities.'⁹⁷

2.46 In *'Nature and extent of violence, abuse, neglect and exploitation against people with disability in Australia'*, a report commissioned by the Royal Commission, the Centre for Research Excellence in Disability and Health recognises the exclusion of sterilisation and other restrictive practices from conventional understandings of violence:

Currently, there is no consistent approach to defining or identifying violence, abuse, neglect and exploitation against people with disability in Australia. Information is mostly drawn from data collections that typically ask about forms of violence that are common across the population (e.g., physical and sexual violence; domestic and family violence). While these data tell us about the nature, extent and impact of some types of violence for people with disability in comparison to people without disability, they fail to capture additional behaviours and manifestations of violence that may be specific to, or even experienced exclusively by, people with disability.

This includes, for example, violence that is targeted at people with disability because of their perceived vulnerability (also known as hate, disablist hate or bias crimes); denial of treatment, required medication and/or specific aids; limiting access to social and other support services and exploitation/violation of bodily autonomy including forced or coerced sterilisation. Information about these less commonly understood expressions of violent, abusive, neglectful and exploitative behaviours and practices rely primarily on formal disclosure and recording and currently there is little to support understanding about its nature and extent.

We encourage the Disability Royal Commission therefore to explore the full scope of what violence, abuse, neglect and exploitation means for people with disability; the way it is enacted through a diverse range of incidents, consistently as part of

*everyday experiences and through the operations of family structures, relationships, institutions, service delivery and policy and legislative settings.*⁹⁸

- 2.47 In 2015, the Victorian Office of the Public Advocate produced a report on a project which was conducted at the request of the Australian Government ‘on sterilisation data collection practices’ which ‘relates to sterilisation applications and medical procedures that result in sterilisation of persons with cognitive disabilities across all Australian jurisdictions’.⁹⁹ One of the goals of the project was to: ‘enable Boards and Tribunals to be able to report back against the data indicators’,¹⁰⁰ and one of the objectives was to: ‘standardise data collection practices of state and territory courts and tribunals regarding sterilisation applications and medical procedures that result in sterilisation, and determine the most appropriate place for annual publication.’¹⁰¹ One of the outputs was an agreed, ‘consistent set of indicators for data collection on sterilisation applications and medical procedures that result in sterilisation across all state and territory jurisdictions’, including ‘a consistent approach to data on the number of applications, the nature of the procedures applied for, the age of patients, the nature of disabilities, alternate treatments considered, the categories of parties to the proceedings, the outcome of applications and any other relevant data.’¹⁰² The indicators for data collection purposes are: number of applications, age and age bracket of person, gender of person, primary disability of person, applicant, proposed procedure, alternative treatment/s considered, other parties to the application (including whether Public Advocate/Guardian is a party), primary reason for application, outcome of application, date application received, date application heard, and date decision made. There are annual reports available on AGAC’s website,¹⁰³ but these *only* report on number of sterilisations authorised per jurisdiction, and do not provide the level of detail reflected in the indicators. These reports are an important source of data, but they do not extend to menstrual suppression and contraceptives that have long-term but not permanent effects. Moreover, they do not extend to sterilisation of children, sterilisation of adults other than those with cognitive impairment, and sterilisation authorised under other laws such as mental health laws, family law or common law *parens patriae* doctrine. These data do not provide *any* qualitative information about the personal and legal circumstances of the decisions.
- 2.48 The National Disability Insurance Scheme Quality and Safeguarding Commission (NDISQSC) collects *some* data on authorised and unauthorised restrictive practices, including in relation to menstrual suppression and contraceptives. However, accurate and comprehensive data on menstrual suppression and contraceptives is not readily available. Data accessed by one of the Submission authors through a Freedom of Information (FOI) request¹⁰⁴ extends to contraceptives, contraceptive devices and certain drugs in relation to NDIS participants with behaviour support plans, but does not disaggregate in terms of which of these are used principally for menstrual suppression as opposed to principally for contraception, and which of these are used as chemical restraint and which are prescribed for medical treatment. Data on unauthorised restrictive practices in relation to menstrual suppression and contraceptives was not accessible through the FOI request. There is also no data which is publicly available or easily accessible pursuant to FOI on compliance and enforcement actions in relation to unauthorised restrictive practices disaggregated in relation to gender and menstrual suppression and contraceptives.
- 2.49 There are three particular challenges in relation to data collection in the specific context of sexual and reproductive violence against women and girls with disability which is facilitated through use of restrictive practices, is authorised by courts or tribunals and/or occurs through medical care:
- **Restrictive practices:** As noted by the Centre for Research Excellence in Disability and Health, restrictive practices do not fall within data collection on domestic and family violence.¹⁰⁵ NDISQSC does not make available

disaggregated data on restrictive practices.

- **Courts or tribunals:** Courts or tribunals that typically authorise sterilisation, restrictive practices and removal of children – Supreme Court protective list, guardianship tribunals, mental health tribunals, Children’s Courts – have closed proceedings and/or limited public access to court information (as we discussed in further detail in our Submission to the DRC on Restrictive Practices).¹⁰⁶
- **Medical care:** Procedures such as sterilisation, abortion, and implanted contraception are not always captured accurately in Medicare data (the key source of data in this context) and prescription of oral contraception is not captured in Medicare data. Moreover, some medical procedures for sterilisation can occur overseas and thus outside of any Australian data collection systems.

2.50 Production of data, research and studies in the context of sexual and reproductive violence against women and girls with disability is a human rights obligation in terms of domestic implementation of the CRPD, the *Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)*, and other human rights treaties to which Australia is a party. Moreover, data has an important role in legal and political accountability, and in community recognition of the violation and humanity of people with disability.¹⁰⁷

2.51 For more than a decade, the United Nations (UN) has been critical of Australia for its neglect of women and girls with disability in all aspects of data collection, information and research,¹⁰⁸ and has repeatedly called on the Australian Government to address this neglect as a matter of urgency. For example, following her mission to Australia, the Special Rapporteur on Violence Against Women, its causes and consequences recommended the Australian Government:

*Implement the recommendation made by the Committee on the Rights of Persons with Disabilities that the Government commission and fund a comprehensive assessment of the situation of girls and women with disabilities, in order to establish a baseline of disaggregated data against which future progress towards the implementation of the Convention could be measured.*¹⁰⁹

2.52 These strong recommendations from the UN are consistent with recommendations made to successive Australian Governments by civil society organisations, parliamentary inquiries and other fora.¹¹⁰ Yet to date, such recommendations are yet to be enacted. There has been little progress in this area, and women and girls with disability continue to be excluded from policies, programs, services and measures to progress gender equality – including in relation to restrictive practices and the right to freedom from all forms of violence.

2.53 The UN has also clarified that Article 31 of the CRPD (*Statistics and Data Collection*) is not solely concerned with collection of demographic statistics on prevalence and types of disability or impairment, but also with data on the extent of compliance or otherwise with the requirements of the CRPD. It is inherently difficult for States Parties to report on CRPD implementation without benchmarking data on initial levels of compliance. The UN has made clear that Australia must develop nationally consistent measures for data collection and public reporting of disaggregated data across the full range of obligations contained in the CRPD, and that *all* data must be disaggregated by gender.

2.54 Comprehensive data collection on sexual and reproductive violence initiated by the Royal Commission will be vital to properly responding to this violence and ultimately realising sexual and reproductive rights and justice for women and girls with disability.



3 MOVING FORWARD: KEY AREAS OF ACTION ON SEXUAL AND REPRODUCTIVE VIOLENCE FOR THE ROYAL COMMISSION

3. MOVING FORWARD: KEY AREAS OF ACTION ON SEXUAL AND REPRODUCTIVE VIOLENCE FOR THE ROYAL COMMISSION'S WORK

- 3.1 In this section we identify key areas of action for the Royal Commission based on its work to date on sexual and reproductive violence.

Centring Experiences and Perspectives of Women and Girls with Disability

- 3.2 Firstly, it is important that in future work the Royal Commission centres experiences and perspectives of people with disability, including women and girls with disability.
- 3.3 Over two-million women and girls with disability live in Australia (approximately 18% of the population of women).¹¹ There is no data or information on the number of feminine identifying and non-binary people with disability in Australia. Women and girls with disability in Australia come from a range of backgrounds, lifestyles, beliefs and communities. They may be First Nations or come from culturally and linguistically diverse communities. They may have a faith, or not; be married, divorced, partnered, or single; gay, lesbian, bisexual, transgender or intersex; parents, guardians, carers, and friends. They may or may not be in paid work, or they may be engaged in education and training. Each of these contexts can, and does, affect how, when, why, and in what form a woman or girl with disability accesses, receives and/or is denied, services and supports. Further, these contexts can also influence how or if, and to what extent, women and girls with disability are included in social, political, cultural and economic opportunities and participation in community life.
- 3.4 As WWDA has stated, it is vital to centre the voices and experiences of women and girls with disability in addressing sexual and reproductive violence:

It is largely through the actions of women with disability themselves – locally, nationally and globally – that this history and culture of exclusion and inaction [in relation to sexual and reproductive rights] is being challenged, and women with disability are demanding and reclaiming their sexual and reproductive rights and freedoms. Women with disability argue that one of the best ways to challenge oppressive practices, cultures and structures is to come together with other women with disability – to share experiences, to gain strength from one another and to work together on issues that affect them. Through organisations like WWDA – run by and for women and girls with disability - women with disability are afforded a mechanism to become actively and genuinely involved in organising for their rights – defining their issues, making decisions about factors that affect their lives, participating in the formulation and implementation of policies, programs and services and, taking individual and collective action to claim and advance their human rights and freedoms.¹²

- 3.5 Disability Royal Commission Term of Reference (g) directs the Commissioners to have regard to:

the specific experiences of violence against, and abuse, neglect and exploitation of, people with disability are multi-layered and influenced by experiences associated with their age, sex, gender, gender identity, sexual orientation, intersex status, ethnic

*origin or race, including the particular situation of Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people with disability;*¹¹³

- 3.6 Commissioner Sackville, Chair of the Royal Commission, states in his Foreword to the Royal Commission's 'Accessibility and Inclusion Strategy' that the Royal Commission is committed 'to putting people with disability at the forefront of its work'.¹¹⁴ The Strategy states:

*Women and girls with disability are far more likely to experience violence and abuse than women and girls without disability, and they are less likely to report this abuse for both personal and systemic reasons. We provide a confidential and supportive environment for women and girls to engage with us.*¹¹⁵

- 3.7 Addressing the experiences of women and girls with disability is particularly important because Australia has received numerous recommendations from the UN to investigate, address and remedy the high incidence and prevalence of violence against women and girls with disability. Very few of these recommendations have been implemented by successive Australian Governments.
- 3.8 In its Interim Report, the Royal Commission identifies women with disability as one of a small number of groups that the Royal Commission's Community Engagement Team 'has carried out or is planning engagement activities to increase [their] voice'.¹¹⁶ However, a specific, targeted Engagement Plan for women and girls with disability is yet to be made publicly available.
- 3.9 In order for the Royal Commission to fully meet its Terms of Reference and its commitment to foregrounding people with disability, it is vital that it centre the voices and experiences of women and girls with disability. It is encouraging that the Royal Commission has held a two part scheduled hearing on violence against women and girls with disability: Public hearing 17: The experience of women and girls with disability with a particular focus on family, domestic and sexual violence (Part 1) held online on 13 and 14 October 2021 and Public hearing 17.2: The experiences of women and girls with disability with a particular focus on family, domestic and sexual violence (Part 2) held in Hobart on 28 March 2022 to 1 April 2022.¹¹⁷ This two part hearing was a vital aspect of the Royal Commission's work exploring intersectional dimensions of women and girls with disability's experiences of violence, abuse, neglect and exploitation. At the Hobart hearing in March 2022, evidence given by witnesses confirmed the occurrence and life-long trauma of forced and/or coerced sterilisation, abortion and/or menstrual suppression (in addition to other experiences of violence, abuse, neglect and exploitation by women and girls with disability). WWDA gave evidence at the Hobart hearing calling for the abolition of these practices as a serious breach of human rights and recommended a redress scheme be established for women and girls with disability who have been subjected to these egregious human rights violations. In giving evidence, amongst other things, WWDA also strongly advocated for:
- the repeal of all laws that are not consistent with the CRPD.
 - the development and enactment of national legislation on all forms of gender-based violence against women.
 - the urgent development and enactment of national legislation to prohibit forced sterilisation of girls and women with disability.
 - Australian Governments to fully implement their obligations under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) to ensure that OPCAT implementation in Australia includes the inspection and monitoring of "any

place in which a person is deprived of liberty (in the sense of not being free to leave)”, which must extend to settings such as: psychiatric hospitals, compulsory care facilities, community-based residences (including disability group homes and respite centres), aged care facilities, child welfare institutions, hospital emergency rooms where patients may be subject to physical or chemical restraint, seclusion rooms in educational settings, boarding schools and rehabilitation facilities.¹¹⁸

- 3.10 While this 2 part Public Hearing was promising, it is vital that the Royal Commission thread intersectionality and specific experiences of women and girls with disability *throughout all* its work. To date, there has been little to no focus on intersections between disability and gender and there has been a lack of identification and deeper exploration of gendered dynamics of violence, abuse, neglect and exploitation and specific experiences of women and girls with disability. Public Hearings, Community Forums and Issues Papers have been largely gender-neutral. Gender-neutrality creates and perpetuates the consequences of gender-based discrimination and contributes to misleading analyses of issues and inaccurate assessments of likely policy outcomes. As such, we are concerned the gender neutrality in much of the Royal Commission’s public work will lead to the Royal Commission making recommendations that do not respond to the specificities of women and girls with disability’s experiences of violence, abuse, neglect and exploitation, including in the context of sexual and reproductive violence.
- 3.11 The Royal Commission’s work on sexual and reproductive violence must centre the voices and experiences of women and girls with disability. Women and girls with disability – rather than legal, health and social professionals or service providers – are the experts on their experiences and what should happen to their bodies and lives. WWDA asks that the Royal Commission, in consultation with women and girls with disability and their representative organisations, conduct stand-alone Public Hearings, as well as forums, roundtables and other engagement activities to examine the specific experiences of women and girls with disability in relation to sexual and reproductive violence. Since the announcement of the Royal Commission in April 2019, we have repeatedly requested that the Royal Commission establish an expert advisory group of women and girls with disability and their representative organisations to provide advice on: the situation of women and girls with disability in all areas of examination; specific areas of examination that disproportionately impact on women and girls with disability; the process of examinations, findings and recommendations; and other related matters. It is regrettable that to date, this has not occurred. We re-iterate, as in many of our previous Submission to the Royal Commission, that it is critical that the Royal Commission provide safe, supportive spaces and trauma-informed approaches to enable women and girls with disability to engage with the Royal Commission without fear of retribution. This is consistent with CRPD General Comment 3¹¹⁹ and CRPD General Comment 7. Additionally, we believe it is critically important for the Royal Commission to hold a **stand-alone** Public Hearing on Sexual and Reproductive Rights Violations of People with Disability, prior to the end of the Royal Commission. This issue is vast, and cannot be properly examined without a Public Hearing dedicated solely to interrogating the sexual and reproductive rights violations of all people with disability – as per Term of Reference G.¹²⁰
- 3.12 Many forms of sexual and reproductive violence against women and girls with disability are perpetrated through legal, routine and normalised practices of legal, health and social care professionals and service providers. Indeed, in recognition of the capacity for professionals to perpetrate violence, some professional associations have recently apologised for the role of their members in violence perpetrated against other marginalised groups, notably First Nations people and members of the Stolen Generations.¹²¹ The Royal Commission should not take for granted the objectivity and legitimacy of legal, health and social care knowledge and professional expertise and take at face value their ‘expert’ opinions on people with disability and, rather than assuming the benevolence of service providers

(including not for profit service providers). Rather, it is important the Royal Commission not only questions, but fully interrogates, the ableism (including gendered ableism) and epistemic and ontological violence embedded in professional knowledge about disability, and scrutinise the views and practices of legal, health and social care professionals and service providers towards people with disability (including women and girls with disability). Such an approach reflects the Royal Commission's recognition of the role of discriminatory and stigmatising community attitudes about disability in violence, abuse, neglect and exploitation of people with disability¹²² and its aspiration (in the words of Commissioner Sackville) to 'transform community attitudes and bring about changes to policies and practices'.¹²³

- 3.13 Further, WWDA strongly urges the Royal Commission to make full use of its procedural powers, to call legal, health and social care professionals and service providers as witnesses under oath and compel them to give evidence in the context of their roles in the perpetration of violence, abuse, neglect and exploitation of people with disability, including sexual and reproductive violence against women and girls with disability. The systemic and structural nature of violence, abuse, neglect and exploitation of people with disability means that accountability of legal, health and social care professionals and service providers is central to responding to and preventing violence, abuse, neglect and exploitation of people with disability. While there has been some engagement with health and social care professionals and disability service providers, to date the attitudes and practices of legal professionals and the judiciary have not been subject to any scrutiny about their complicity in violence, abuse, neglect and exploitation. People with disability and advocates continue to express their concern that the views of "professionals, academics, government representatives, and service providers" appear to be given more legitimacy (by the Royal Commission) than people with disability themselves.

Taking a Gender-Inclusive Approach to Violence

- 3.14 Second, it is important that in future work the Royal Commission takes a gender inclusive approach to violence, abuse, neglect and exploitation, and specifically engages with sexual and reproductive violence. Such an approach involves recognising and investigating forms of violence related to various domains of sexuality and reproduction:
- **Menstruation:** forced and/or coerced menstrual suppression; denying supports to menstruate.
 - **Reproduction:** forced and/or coerced contraception; denying access to consensual contraception; denying access to assisted reproductive technologies or prenatal services; discrimination in accessing assisted reproductive technologies and prenatal services; forced and/or coerced abortion.
 - **Sexual identity, expression and activity:** denying supports for positive sexual experiences; preventing or punishing expressions of non-normative gender or sexual identity and sexual experiences; gender-based violence (including in closed, segregated and institutional settings); discriminatory and inaccessible justice system responses to gender-based violence.
 - **Intimate relationships:** denying support for co-habitation and intimate relationships; coercive interventions to prevent co-habitation or intimate relationships; discriminatory and inaccessible justice system responses to gender-based violence.
 - **Sexual and reproductive health:** denying access to sexual and reproductive

health services, information, education and resources; discrimination in access to sexual and reproductive health services, information, education and resources.

- **Parenting:** discrimination in provision of parenting and family services; child protection interventions; discriminatory and inaccessible child protection justice systems; discriminatory private family law parenting arrangements.

3.15 As is apparent from the examples in relation to each of these domains, some dimensions of sexual and reproductive violence relate to unwanted physical interventions in relation to negative sexual and reproductive experiences, whereas at other times the violence arises from a failure to provide the supports for positive and wanted sexual and reproductive experiences. As these examples do not necessarily fit within conventional understandings of violence, abuse, neglect and exploitation we urge the Royal Commission to closely interrogate its approach to ensure it encapsulates and is attentive to gendered forms of violence, abuse, neglect and exploitation. This is particularly because the preamble to the Royal Commission indicates it is tasked with preventing all forms of violence, abuse, neglect and exploitation of people with disability (not only that which is illegal under criminal law):

*all forms of violence against, and abuse, neglect and exploitation of, people with disability are abhorrent.*¹²⁴

Similarly, Term of Reference A states:

*what governments, institutions and the community should do to prevent, and better protect, people with disability from experiencing violence, abuse, neglect and exploitation, having regard to the extent of violence, abuse, neglect and exploitation experienced by people with disability in all settings and contexts;*¹²⁵

3.16 It is recognised that the Royal Commission's Terms of Reference acknowledge in general terms the need to explore experiences of women and girls with disability:

*... the specific experiences of violence against, and abuse, neglect and exploitation of, people with disability are multi-layered and influenced by experiences associated with their age, sex, gender, gender identity, sexual orientation, intersex status, ethnic origin or race, including the particular situation of Aboriginal and Torres Strait Islander people and culturally and linguistically diverse people with disability.*¹²⁶

3.17 The Royal Commission's working definition of 'violence' explicitly includes some of the forms of violence we have identified:

*Violence and abuse cover a range of behaviours towards people with a disability. These could include assault, sexual assault, constraints, restrictive practices (physical and chemical), forced treatments, forced interventions, humiliation and harassment, financial and economic abuse and significant violations of privacy and dignity on a systemic or individual basis.*¹²⁷

3.18 In its Public Hearing 17: The experience of women and girls with disability with a particular focus on family, domestic and sexual violence (Part 1), the Royal Commission heard from a range of witnesses, including representatives from DPOs for women and girls with disability (e.g., Carolyn Frohmader, Executive Director of WWDA), gender-based violence service providers, and researchers. This hearing focused on gender-based violence causes and responses. However, through evidence given by Carolyn Frohmader and Dr Linda Steele it also explored violence, abuse, neglect and exploitation of women and girls with disability in the context of sexual and reproductive rights. Their evidence focused primarily on sterilisation and other forms of legally authorised violence, and the need to respond

to this violence through reform to legal and justice systems and introduction of a redress scheme. It was however, unfortunate that Carolyn Frohmader and Dr Linda Steele were only allocated one hour to provide evidence on the issue of sexual and reproductive rights, which necessitated Ms Frohmader and Dr Steele having to essentially prioritise forced sterilisation and forced contraception as the two issues to focus on, given the short time allocated to the issue. In Public Hearing 17 Part 2, which focused on 'The experiences of women and girls with disability with a particular focus on family, domestic and sexual violence', WWDA gave evidence as a panel, but unfortunately was only allocated one hour to provide evidence. Despite this, WWDA again re-iterated the egregious sexual and reproductive rights violations that women and girls with disability experience and are at higher risk of, and called for urgent legislative reforms to address these.

- 3.19 Elsewhere in the Royal Commission's Issues Papers and Public Hearings there has been piecemeal engagement with sexual and reproductive violence.
- 3.20 In its Issues Paper on violence and abuse of people with disability at home,¹²⁸ the Royal Commission recognises some forms of gender-based violence, and also discusses some of the data and dynamics on violence in the home against women and girls with disability.¹²⁹ This issues paper also discusses whether all violence that occurs in the home should be conceptualised and responded to as 'domestic violence'.¹³⁰ This issues paper notes challenges and barriers specifically for culturally and linguistically diverse women with disability.¹³¹
- 3.21 While the Group Homes Issues Paper does not explore sexual and reproductive violence, a number of hearings have considered unlawful sexual violence in group homes. Public Hearing 3 on group homes (2019) considered disability service responses to unlawful sexual violence in group homes. Public Hearing 13 on the Sunnyfield case study (2021) considered disability service response to physical violence against a woman with disability. Public Hearing 20 on the Life Without Barriers case study (2021) considered the support provided by Life Without Barriers provided to a disabled woman who had been sexual assaulted. While each of these hearings highlighted significant, systemic and longstanding issues about the lack of trauma-informed support, access to justice systems and access to redress for women and girls with disability living in group homes, to date these hearings have not resulted in any consequences in terms of accountability of service providers and redress to victim-survivors.
- 3.22 The Employment Issues Paper states: 'there is research that suggests women with disabilities who work in ADEs may be at an increased risk of sexual harassment or sexual violence and feel less able to make a complaint, seek assistance or find relevant information when harassment or violence does occur'.¹³² The Royal Commission's Public Hearing 22 on 'The experience of people with disability working in Australian Disability Enterprises' held in April 2022, failed to interrogate the gendered dynamics of ADEs, including the prevalence and incidence of sexual violence against women with disability working in these settings.
- 3.23 The Rights and Attitudes Issues Paper notes that 'women with disability report being targeted with negative attitudes more often than men'¹³³ and the overview of responses to the Rights and Attitudes notes some submissions that identified the impact of negative attitudes towards women with disability, including in relation to the perpetration of and disability service and justice system responses to sexual violence.¹³⁴
- 3.24 The Health Issues Paper identifies as a set of barriers and issues in the health context: '*Attitudes and assumptions, which may influence issues such as: ... lack of sexual and reproductive health care*'.¹³⁵ However, beyond attitudes and assumptions, the Health Issues Paper does not discuss denial of access to reproductive and sexual healthcare or

discrimination experienced in accessing that healthcare, nor health system involvement in forced and coercive sterilisation, menstrual suppression, contraception and abortion. The related Public Hearings on health care and services for people with cognitive disability contained passing reference to prescription of the contraceptive pill to a woman with Down Syndrome, but this is focused on the unknown/under-researched side effects of the pill on women with Down Syndrome and did not explore the prescription of the pill as an issue of restrictive practice or violence.¹³⁶ The overview of responses to the Health Issues Paper does note that:

Several respondents discussed doctors prescribing medicine and contraceptives without consent and parents seeking information about sterilisation without their adult child's consent.

Family Planning NSW expressed concern about the quality of reproductive and sexual health care for people with intellectual disability, highlighting that some doctors provide women with contraception without explaining what it is for, based on the requests of the parent/carers or support person. Women may be told that contraception is only for skincare or other non-contraceptive purposes.¹³⁷

3.25 In many respects the Royal Commission has missed opportunities to explore sexual and reproductive violence in its existing work. For example, as we discuss in some detail in our Restrictive Practices submission, the Restrictive Practices Issues Paper¹³⁸ does not include any mention or analysis of the specific circumstances of women and girls with disability, nor does it consider gendered restrictive practices, notably forced and coercive sterilisation, abortion, contraception and menstrual suppression. Moreover, it is not clear from Royal Commission's exploration of disability service responses to unlawful sexual violence, across three Public Hearings, that it intends to make any findings and recommendations concerning issues of accountability and redress vis-à-vis disability service providers.

3.26 The absence of consideration of sexual and reproductive violence in the Royal Commission's work must be understood in the context of longer term marginalisation in government inquiries and law reform reviews (as discussed earlier in Section 2).

3.27 In its Interim Report, the Royal Commission identifies a set of emerging themes:

A number of themes have emerged as particularly pertinent to the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation. The themes include:

- *choice and control*
- *attitudes towards disability*
- *segregation and exclusion*
- *restrictive practices*
- *access to services and supports*
- *advocacy and representation*
- *oversight and complaints*
- *funding.¹³⁹*

3.28 Moreover, in its Interim Report the Royal Commission identifies key issues:

We have heard about key issues across systems and services, including:

- *education and learning*
- *homes and living*
- *health care*
- *relationships*
- *community participation*

- *economic participation*
- *the NDIS*
- *the justice system.*¹⁴⁰

3.29 Sexual and reproductive violence against women and girls with disability cuts across all of these themes (particularly choice and control, restrictive practices, attitudes towards disability, and segregation and exclusion) and issues (particularly relationships, health care, and the NDIS). It is hoped the Royal Commission will give specific consideration to sexual and reproductive violence in its future work on these themes.

3.30 In the Interim Report the Royal Commission identifies issues pertaining to sexual and reproductive violence in its discussion of health care and relationships.¹⁴¹ Also in the Interim Report there are some specific references to sexual and reproductive violence, including the absence of data on use of sterilisation¹⁴² and suggestions at a Royal Commission hearing ‘that some women with disability in group homes are subjected to forced contraception’.¹⁴³ The Interim Report also notes the significance of child removal from parents with disability, notably First Nations parents with disability.

*The Royal Commission has also received information about circumstances where children have been removed from a parent or parents with disability. We have heard from adults with disability about being removed from their families when they were children. We have heard about these experiences for First Nations families in the context of historical and current practices of child removal.*¹⁴⁴

3.31 In the course of its discussion of the emerging issue of ‘relationships’, the Royal Commission states in its Interim Report:

*Throughout the course of our inquiry we will examine the nature and extent of violence against, and abuse, neglect and exploitation of, people with disability in the context of relationships, including abuse related to sexual and reproductive rights, and violence between people with disability. We will also inquire into the barriers to parenting experienced by people with disability, and the roles of families and carers.*¹⁴⁵

3.32 The Interim Report also notes historical practices of sterilisation, when setting out the historical context of the Royal Commission.¹⁴⁶ However, the Royal Commission does not indicate how it will be considering historical injustice, including historical injustices related to sexual and reproductive violence, as part of violence, abuse, neglect and exploitation of people with disability.

3.33 WWDA trusts that all of these issues about sexual and reproductive violence that are merely mentioned in the Interim Report, will be given in-depth consideration in the Royal Commission’s future work. As highlighted earlier, we also believe it is critically important for the Royal Commission to hold a stand-alone Public Hearing on Sexual and Reproductive Rights Violations of People with Disability.

The Importance of Considering the Role of Legal and Justice Systems in Enabling and Responding to Sexual and Reproductive Violence Against Women and Girls with Disability

3.34 Many forms of sexual and reproductive violence are enabled by laws, authorised by justice systems, done pursuant to judges’ decisions and orders, and supported by government funding and bureaucracies. Legal and justice systems are not inherently benevolent, protective and empowering for women and girls with disability. Instead these systems are very much complicit in enabling sexual and reproductive violence and in preventing redress and broader realisation of sexual and reproductive rights.

3.35 Yet, to date the Royal Commission has not explored the role of laws, courts/tribunals, and the legal profession and judiciary in perpetration of violence against people with disability. Instead the focus been on systems that enact violence, abuse, neglect and exploitation ‘on the ground’, such as disability services, health, education, employment and criminal justice systems. This focus is concerning because behind much of the violence, abuse, neglect and exploitation ‘on the ground’ are legal frameworks and court and tribunal orders that authorise the enacting of this violence, abuse, neglect and exploitation, protect perpetrators from accountability and deny redress to victims/survivors. Overlooking in-depth exploration of legal and justice systems risks the absence of recommendations addressing these systems, and thus any changes to ‘on the ground’ systems focused on changing practice and cultures that give rise to instances of violence, abuse, neglect and exploitation will not remove the legal possibility and permissibility for this violence, abuse, neglect and exploitation. WWDA elaborated on this argument in our earlier Submission to the Royal Commission on Restrictive Practices.

3.36 The Royal Commission must also consider the role of laws, courts/tribunals, and the legal profession and judiciary in responding to and preventing violence, abuse, neglect and exploitation of people with disability. For a variety of reasons, including the ableism (including gendered ableism) in legal doctrine and legal/judicial practice, the financial, physical and cognitive inaccessibility of justice systems, the historical nature of some violence, abuse, neglect and exploitation, and the lawfulness of some forms of violence, abuse, neglect and exploitation, people with disability cannot access redress and justice in response to violence, abuse, neglect and exploitation through the courts. The role of courts in preventing violence – including through deterrence and systems change – might be limited if they cannot ensure accountability and public transparency. These issues must be fully explored by the Royal Commission.

3.37 A redress scheme for individuals who have experienced violence, abuse, neglect and exploitation in the context of a broader reparations framework that encompasses both individual and structural/collective responses is required because of the structural and systemic nature of violence, abuse, neglect and exploitation of people with disability and the failures of legal and justice systems to respond to individual and collective injustices. Yet, despite collective calls by WWDA and DPOA for the Terms of Reference for the Royal Commission to include provision for a redress scheme, this was not included. The absence of redress from the Royal Commission’s Terms of Reference is in stark contrast to the Terms of Reference of the Royal Commission into Institutional Responses to Child Sexual Abuse, which tasked that Royal Commission with inquiring into

*what institutions and governments should do to address, or alleviate the impact of, past and future child sexual abuse and related matters in institutional contexts, including, in particular, in ensuring justice for victims through the provision of redress by institutions, processes for referral for investigation and prosecution and support services.*¹⁴⁷

3.38 In September 2019, the UN CRPD Committee adopted its Concluding Observations following its review of Australia’s compliance with the CRPD. The UN CRPD Committee expressly recommended that the Australian Government: ‘ensure [adequate resources and] a redress mechanism for the Royal Commission.’¹⁴⁸ It remains unclear as to whether the Australian Government will adopt this critical recommendation. In its Group Homes hearing, the Royal Commission heard about the limited response of a disability service to violence against group homes residents.¹⁴⁹ The Royal Commission observed in its Interim Report: ‘it is clear that the question of redress, including compensation for serious harm, is worthy of further investigation.’ It went on to note that:

The Royal Commission proposes to investigate:

- *the forms of redress available to people with disability who are subjected to violence, abuse, neglect or exploitation while residing in group homes or supported accommodation;*
- *measures that should be taken to ensure that when violence, abuse, neglect or exploitation occurs, people receive independent advice and support to enable them to pursue the remedies available to them; and*
- *whether it is feasible to establish a scheme to compensate people with disability who have sustained serious harm from violence, abuse, neglect or exploitation in circumstances where no other redress is available to them.¹⁵⁰*

3.39 While it is encouraging that the Royal Commission identifies redress as an area of future exploration, it is yet to articulate the exact scope and focus of this work. Given the group homes context of its limited discussion of redress, we are concerned that its exploration of redress might be limited to contemporary residential settings and thus not cover contemporary instances of violence, abuse, neglect and exploitation in other settings and contexts, nor would it cover historical instances of violence, abuse, neglect and exploitation of people with disability in any setting or context. It is unclear whether the Royal Commission's exploration of redress will extend to restrictive practices given the group homes case study related to unlawful sexual and physical assault. Moreover, it is unclear what is meant by a redress scheme which would be available where 'no other redress is available to them', such as whether this would require an individual exhaust all court-based legal remedies (irrespective of the ableism and significant access to justice barriers experienced by people with disability) or on the other hand if this would cover restrictive practices which by reason of their lawfulness are an exemplar of violence, abuse, neglect and exploitation where 'no other redress is available'. WWDA supports the broadest possible exploration of redress, across all forms of violence, abuse, neglect and exploitation (including all forms of sexual and reproductive violence), across all settings contexts (not only residential settings), and across all time periods (contemporary and historical).

Cultural Dynamics of Sexual and Reproductive Violence

3.40 The establishment of the Royal Commission is an opportunity to go beyond investigation of life domains, the operation of service systems, the quality of support workers, and protective mechanism responses, and to undertake a comprehensive investigation of ableism, inequality and intersectional discrimination in Australian law, policy and practice. Further, the establishment of the Royal Commission allows for the exploration of community attitudes generally in order to *explicitly* expose and address the underlying cultural, social, legal and economic drivers or enablers of sexual and reproductive violence against women and girls with disability and beyond this to realise sexual and reproductive rights. We suggest the Royal Commission take an approach that balances in-depth, nuanced examination of specific forms and instances of perpetration of violence with a broader examination of sexual and reproductive violence in relation to epistemologies and ontologies of disability, ongoing role of eugenic logics, interconnected service systems and legal frameworks, longer term dynamics of control of people with disability, lifelong and intergenerational trajectories, and interlocking dynamics and systems of oppression.

3.41 It is particularly important that the Royal Commission situate its exploration of sexual and reproduction violence in the context of cultural ideas about disability and eugenic logics. By eugenic logics, we mean ways of thinking about disability that is based on hierarchies of

which social groups are worthy of access to support and resources in order to flourish, live and survive, based on the relative economic value of these groups to the overall prosperity of the nation. While eugenics is associated with early twentieth-century policies and practices towards disabled people, notably sterilisation and institutionalisation, these same logics continue to underpin laws and practices towards people with disability, particularly in relation to sexuality and reproduction. We know from the past decade, since the coming into force of the CRPD, that the mere existence of human rights is not enough to disrupt these eugenics logics, as confirmed by the experiences of people with disability during the COVID-19 pandemic. Nor is the mere existence of human rights enough to convince law reformers and law and policy makers about the necessity of taking action in relation to sexual and reproductive violence (as demonstrated in the overview of past inquiries in Section 2). In part, this inaction is attributable to deep-set and persistent *ontological* assumptions about *what* disability is, who people with disability are and how they should be in their bodies and in the world, and *epistemological assumptions* about *who* has the authority to make these claims. These assumptions do not merely inform community (i.e. the person on the street) opinions about disability, they also set the parameters for the privileging of academic, bureaucratic and professional expertise on disability and the current legality of many forms of sexual and reproductive violence. These assumptions also legitimate use of sexual and reproductive violence for economic efficiency and convenience. As such, WWDA urges the Royal Commission to carefully analyse the specific attitudes towards disability and people with disability in the epistemic and ethical frameworks of legal, health, social care disciplines and professions (even when these are framed in terms of scientific objectivity).

- 3.42 Without a sound understanding of how society in general and legal, health and social care disciplines and professions construct disability, and the ways in which different systems and structures of oppression intersect to shape the experiences of discrimination and violence, it is more likely that those tasked with shaping or implementing policies will develop solutions better suited for short-term fixes instead of long-term structural change.



4 SEXUAL AND REPRODUCTIVE RIGHTS IN INTERNATIONAL HUMAN RIGHTS LAW

4. SEXUAL AND REPRODUCTIVE RIGHTS IN INTERNATIONAL HUMAN RIGHTS LAW

4.1 This section provides an overview of sexual and reproductive rights in international human rights law. International human rights is the starting point of our exploration of sexual and reproductive violence because it effects a shift in how disability and violence, abuse, neglect and exploitation are understood from a narrow individualised, paternalistic and medicalised approach to an approach focused on structural, political, cultural and legal dynamics in which ableism is the key organising concept. This shift then centres matters of justice and equality in how we conceptualise and respond to sexual and reproductive violence. As Frohmader and Sands explain:

A human rights approach to conceptualising violence against people with disability – mandated through Australia’s international human rights obligations - underscores the interdependence and indivisibility of civil, political, economic, social and cultural rights. It situates violence against people with disability on a continuum that spans interpersonal and structural violence; acknowledges the structural aspects and factors of discrimination, which includes structural and institutional inequalities; and analyses social and/or economic hierarchies between women and men and also among women. In so doing, it explicitly interrogates the places where violence against people with disability coincides with intersecting forms of discrimination and their attendant inequalities. A human rights approach therefore, specifically acknowledges that people with disability experience significant intersecting forms of discrimination and this is no different when they become victims of violence, including its gender-based dimensions. These intersecting forms of discrimination cannot be ‘disconnected’ from each other when endeavouring to prevent and address violence against people with disability.¹⁵¹

4.2 This section begins with a general overview of international human rights law and sexual and reproductive human rights. Next, the section explores specific human rights provided by the CRPD, and other international human rights instruments as they relate to sexual and reproductive violence against women and girls with disability. These are explored thematically: equality and non-discrimination, freedom from violence, justice and redress, and participation, inclusion, and access to resources and supports. Last, the section surveys key observations on Australia’s compliance with international human rights obligations as they pertain to sexual and reproductive rights of women and girls with disability.

4.3 Australia is a signatory to seven core international human rights treaties.¹⁵² As a party to these treaties, Australia has chosen to be bound by the treaty requirements and has an international obligation to implement the treaty provisions through its laws and policies. Together, the seven international human rights treaties to which Australia is a party – along with their Optional Protocols,¹⁵³ General Comments¹⁵⁴ and recommendations adopted by the bodies monitoring their implementation – provide the framework to delineate the obligations and responsibilities of Governments and other duty-bearers to comprehensively promote the human rights of women and girls with disability, including in relation to violence.

4.4 It is encouraging that the Royal Commission’s Terms of Reference explicitly embed international human rights and explicitly reference the CRPD:

RECOGNISING that people with disability are: equal citizens and have the right to the full and equal enjoyment of all human rights and fundamental freedoms, including respect for their inherent dignity and individual autonomy. ...

AND Australia has international obligations to take appropriate legislative, administrative and other measures to promote the human rights of people with disability, including to protect people with disability from all forms of exploitation, violence and abuse under the Convention on the Rights of Persons with Disabilities.¹⁵⁵

- 4.5 Prior to the development and adoption of the CRPD, the application of human rights to the issues and concerns of women and girls with disability were largely invisible and not addressed.¹⁵⁶ Thus, the CRPD is a response to this lack of recognition of the rights of persons with disability. Until the CRPD, specific issues and concerns for women and girls with disability were mainly articulated, in varying degrees, within the jurisprudence developed under the CEDAW¹⁵⁷ and the Convention on the Rights of the Child (CRC).¹⁵⁸
- 4.6 While it is important that the work of the Royal Commission is framed within and underpinned specifically by the CRPD, it is imperative that the Royal Commission also engages with other human rights treaties. Implementation of the seven core international human rights treaties to which Australia is a party is not mutually exclusive. These treaties are expected to be viewed and implemented as complementary mechanisms through which to create a holistic framework of rights protection and response for all people with disability.¹⁵⁹ For example, for more than a decade, several of the international human rights treaty monitoring bodies have provided guidance on the interpretation and application of international human rights laws as they relate to sexual and reproductive rights, including in the context of making recommendations to Australia in relation to sterilisation and violence against women and girls with disability more broadly. We urge the Royal Commission to consider all of these recommendations in its work, not just those stemming from the CRPD.
- 4.7 To the extent that the Royal Commission focuses on the CRPD, we note that this treaty is *clear* on gender equality. The CRPD recognises gender as one of the most important categories of social organisation. It expressly states the requirement to incorporate a gender perspective in all efforts to promote the human rights of people with disability, meaning that the rights of women and girls with disability must be addressed when interpreting and implementing every article of the CRPD.
- 4.8 The CRPD prioritises women and girls with disability as a group warranting specific attention and additional measures, notably devoting an Article to women and girls (Art 6). It obliges Governments to take positive actions and measures to ensure that women and girls with disability enjoy all human rights and fundamental freedoms. It clarifies the need to ensure that national policies, frameworks and strategies explicitly recognise the impact of multiple discriminations caused by intersections of gender and disability, and that such policies and frameworks include focused, gender-specific measures to ensure that women and girls with disability experience full and effective enjoyment of their human rights.
- 4.9 Despite the obligations of the CRPD in relation to women and girls with disability, it remains the case that in Australian legislative, policy and service contexts, people with disability are still often treated as asexual, genderless human beings. Gender-neutral approaches can result in a failure to recognise and respond to sexual and reproductive violence experienced by women and girls with disability.
- 4.10 Article 6 of the CRPD (*Women with Disabilities*), as a cross-cutting article, means that the rights of women with disability must be specifically identified and addressed in all measures of implementation and monitoring of the CRPD, including in relation to Articles 12, 14, 15, 16, and 17. It is clear that in the Australian context, this is yet to occur.
- 4.11 For a comprehensive discussion of the human rights approach to violence, abuse, neglect and exploitation against people with disability, including women and girls with disability, we

draw the attention of the Royal Commission to the following documents:

- WWDA's submission, as part of DPO Australia (formerly the Australian Cross Disability Alliance) to the *Senate Inquiry into Violence, Abuse and Neglect Against People with Disability*.¹⁶⁰ This submission comprehensively: examines the human rights conceptualisation of 'disability', 'intersectionality' and 'violence against people with disability'; provides information on the scope and prevalence of violence, including gendered disability violence; outlines human rights violations that constitute violence, abuse, neglect and exploitation against people with disability; and highlights failures in the Australian legislative, policy and service landscape in relation to violence.
- The WWDA paper, '*Preventing Violence against Women and Girls with Disabilities: Integrating A Human Rights Perspective*'.¹⁶¹ This paper elaborates on key points made in this submission.
- The '*Women with Disabilities Australia (WWDA) Position Statement: The Right to Freedom from All Forms of Violence*'.¹⁶² This Statement outlines key evidence concerning ongoing violations of Australian women and girls with disabilities' right to freedom from all forms of violence, and highlights specific human rights obligations to ensure that all women and girls with disability can realise their right to freedom from all forms of violence, abuse, exploitation and neglect.
- WWDA's submission to the 2012 Senate Inquiry into Involuntary or Coerced Sterilisation of People with Disabilities in Australia: *Dehumanised: The Forced Sterilisation of Women and Girls with Disabilities in Australia*. This detailed Submission addresses, in detail, the issue of forced and coerced sterilisation of women and girls with disability in Australia.¹⁶³

Sexual and Reproductive Rights in General

- 4.12 Historically, women and girls with disability have been denied recognition of their sexual and reproductive rights:

*While it goes without saying that people with disability have equal rights to sexual and reproductive desires and hopes as non-disabled people, society has disregarded their sexuality and reproductive concerns, aspirations and human rights. People with disabilities are infantilised and held to be asexual (or in some cases, hypersexual), incapable of reproduction and unfit sexual/marriage partners or parents. The sexual and reproductive health and rights (SRHR) of people with disabilities continue to be contested, and there are particular concerns in relation to women with disabilities. For women, disability often means exclusion from a life of femininity, partnership, active sexuality and denial of opportunities for motherhood.*¹⁶⁴

- 4.13 International human rights commentary recognises the importance of sexual and reproductive rights to realising human rights for women and girls with disability.
- 4.14 The UN CRPD Committee has noted that sexual and reproductive health services are a key context of discrimination for women and girls with disability:

There is strong evidence to show that women and girls with disabilities face barriers in most areas of life. These barriers create situations of multiple and intersecting forms of discrimination against women and girls with disabilities, in particular with regard to: equal access to education, economic opportunities, social interaction and

*justice; equal recognition before the law; and the ability to participate in politics and to exercise control over their own lives across a range of contexts, for example with regard to health care, including sexual and reproductive health services, and to where and with whom they wish to live.*¹⁶⁵

- 4.15 In a joint statement in 2018, the UN CRPD Committee and the Committee on the Elimination of All Forms of Discrimination against Women emphasised the importance of sexual and reproductive health:

*The Committees recall that gender equality and disability rights are mutually reinforcing concepts and States parties should guarantee the human rights of all women, including women with disabilities. As such, States parties have an obligation to respect, protect and fulfill the rights of women, including women with disabilities, in relation to their sexual and reproductive health and rights. States must ensure the enjoyment of their sexual and reproductive health and rights without any form of discrimination. Access to safe and legal abortion, as well as related services and information are essential aspects of women's reproductive health and a prerequisite for safeguarding their human rights to life, health, equality before the law and equal protection of the law, non-discrimination, information, privacy, bodily integrity and freedom from torture and ill treatment.*¹⁶⁶

- 4.16 The 2018 joint statement emphasises the importance of autonomy in decision-making on sexual and reproductive health:

*States parties should ensure non-interference, including by non-State actors, with the respect for autonomous decision-making by women, including women with disabilities, regarding their sexual and reproductive health well-being. A human rights-based approach to sexual and reproductive health acknowledges that women's decisions on their own bodies are personal and private, and places the autonomy of the woman at the center of policy and law-making related to sexual and reproductive health services, including abortion care. States should adopt effective measures to enable women, including women with disabilities, to make autonomous decisions about their sexual and reproductive health and should ensure that women have access to evidence-based and unbiased information in this regard. It is also critical that these decisions are made freely and that all women, including women with disabilities, are protected against forced abortion, contraception or sterilization against their will or without their informed consent. Women should neither be stigmatized for voluntarily undergoing abortion nor forced to undergo an abortion or sterilization against their will or without their informed consent.*¹⁶⁷

- 4.17 In a Resolution titled 'Accelerating efforts to eliminate all forms of violence against women and girls: preventing and responding to all forms of violence against women and girls with disabilities' adopted on 13 July 2021, the Human Rights Council calls upon States to 'take immediate and effective action to prevent and eliminate all forms of violence against women and girls', including by:

Fostering respect for the rights and dignity of persons with disabilities, promoting empowering portrayals of women and girls with disabilities and awareness-raising campaigns of their capabilities and contributions, and refraining from supporting or funding campaigns that perpetuate stigmatization or stereotyping of women and girls with disabilities;

Reviewing laws and policies that perpetuate the outdated understanding of disability present in charity and medical models and ableism, and incorporating a human rights-based approach to disability;

Developing, reviewing and strengthening inclusive policies, including by allocating adequate resources to address the historical, structural and underlying causes and risk factors of violence against women and girls ...

Implementing and allocating adequate resources to effective and evidence-based programmes and strategies with and for women and girls with disabilities ...

Ensuring the full, effective and meaningful participation and inclusion of women and girls, in their diverse contexts, including women and girls with disabilities on an equal basis with others, in decision-making processes and leadership roles and in the development and implementation of accessible and inclusive national policies, legislation, procedures, action plans, programmes, projects and strategies to prevent and eliminate violence against women and girls, and ensuring that such participation is conducted in a safe and accessible environment, including through support and capacity-building from organizations of and led by women, girls and other persons with disabilities, and through community outreach, mentoring and capacity-building programmes for women and girls with disabilities;

Ensuring that services and programmes designed to prevent and eliminate violence against women and girls are inclusive of and accessible to women and girls with disabilities, including by ensuring that facilities, services and information are accessible and by providing age- and gender-responsive, disability-inclusive and trauma-informed education and training to professionals, paid care workers and unpaid caregivers working to address the specific requirements of women with disabilities, including older women, and girls with disabilities;

Ensuring that social protection systems address the multiple, interrelated and complex causes of homelessness by preventing poverty, contributing to independent living in the community, health-related goals, gender and racial equality and decent work, and facilitating the inclusion of persons with disabilities;

Taking all appropriate measures to prevent and eliminate all forms of discrimination and violence against women and girls in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters, with particular attention to the risks faced by and the specific requirements of women and girls with disabilities;

Developing and implementing educational programmes and teaching materials in accessible, affordable and alternative formats of communication, including easy to read and understand formats, that raise educators' and learners' awareness about violence against women and girls, ...

Developing and implementing national criminal justice legislation, policies, procedures and programmes that take into account the specific requirements of women and girls with disabilities, and promoting age- and gender-responsive and disability-inclusive measures in crime prevention and protection policies, including capacity-building for those involved in crime prevention, the justice system and informal restorative justice processes;

Supporting initiatives undertaken by, inter alia, international and non-governmental organizations, including women's and girls' rights organizations, organizations of and led by persons with disabilities, older women, girls and youth, civil society actors, the private sector, faith and community groups, religious leaders, politicians, journalists and other media workers, human rights defenders, including women and girl human rights defenders, indigenous peoples, local communities and other relevant actors, as part of their efforts to develop targeted and accessible responses, programmes and

policies, including by allocating adequate financial resources, aimed at promoting gender equality and inclusion and eliminating violence against women and girls;¹⁶⁸

- 4.18 The Human Rights Council also calls upon States to 'take immediate and effective action to respond to all forms of violence against women and girls and to support and protect all victims and survivors', including by:

Holding perpetrators to account and eliminating impunity for all forms of violence against women and girls;

Ensuring that legislation allows for the timely and effective investigation, prosecution, including ex officio prosecution, sanction and redress of violence against women and girls;

Adopting, strengthening and implementing legislation that expressly prohibits violence and provides adequate protection for all women and girls, including women and girls with disabilities, against all forms of violence, in public and private spheres, inter alia violence perpetrated online and offline by support providers, health-care providers, transportation providers and others in positions of authority, and caregivers, sexual harassment, domestic violence, intimate partner violence and gender-related killings of women and girls, and ends impunity and adequately penalizes offences involving physical, sexual, psychological and economic violence occurring in families, in institutions, in digital contexts, in the world of work, in communities and carried out by support providers;

Guaranteeing equal recognition before the law of persons with disabilities, inter alia older women with disabilities, persons with disabilities belonging to minorities, including persons with disabilities of African and Asian descent, migrants with disabilities and indigenous persons with disabilities, and ensuring that they have the opportunity to exercise their legal capacity on an equal basis with others in all aspects of life, as recognized in article 12 of the Convention on the Rights of Persons with Disabilities;

Ensuring access to justice and accountability mechanisms and timely and effective remedies for the effective implementation and enforcement of laws aimed at preventing and eliminating all forms of discrimination and gender-based violence, including by informing women and girls about their rights under relevant laws in an accessible way, providing procedural accommodation for women and girls with disabilities, improving legal infrastructure and mainstreaming age- and gender-responsive and disability-inclusive training into justice systems to ensure equality before the law and equal protection of women and girls with disabilities by the law;

Providing victims and survivors of violence with effective remedies, including victim- and survivor-centred and age- and gender-responsive legal, medical, psychological and confidential counselling services and legal protection that avoid revictimization and re-traumatization and are inclusive of and accessible to women and girls with disabilities, and providing support services, information and education in accessible formats, including on how to prevent, recognize and report instances of exploitation, violence and abuse in any setting;

Fully integrating a human rights perspective into mental health, psychosocial support and community services, and adopting, implementing, updating, strengthening or monitoring, as appropriate, existing laws, policies and practices with a view to protecting the personal integrity of persons with disabilities and eliminating all forms of discrimination, stigma, stereotypes, prejudice, violence, abuse, social exclusion, segregation, unlawful or arbitrary deprivation of liberty on the basis of disability, and institutionalization, and overmedicalization within that context, and promoting the

right of persons with psychosocial disabilities to live independently, to full inclusion and effective participation in society, to decide upon matters affecting them and to have their dignity respected on an equal basis with others;

Ensuring that sexual and reproductive health and reproductive rights are fully realized, including for victims and survivors of sexual and gender-based violence, by addressing the social and other determinants of health, removing barriers, developing and enforcing policies, good practices and legal frameworks, and strengthening health systems that make quality comprehensive sexual and reproductive health-care services, information and education universally accessible and available and inclusive;

Repealing legislation and regulatory provisions that restrict legal capacity or permit forced sterilization, forced abortion and forced contraception and ensuring that any medical procedure or intervention is performed with due regard for the right to respect for physical and mental integrity on an equal basis with others and to bodily autonomy and is not performed without the free and informed consent of women and girls with disabilities;

Strengthening or establishing systems to regularly collect, analyse and publish statistical data disaggregated by sex, age, disability and other relevant characteristics on all forms of violence against women and girls, and using these data to inform more effective efforts across all sectors to prevent and respond to violence, while respecting human rights principles, including participation, transparency, privacy and accountability;¹⁶⁹

4.19 These statements supplement Articles in human rights treaties and other UN documents making explicit reference to sexual and reproductive rights of women generally:

- **Article 16 of CEDAW** guarantees women equal rights in deciding ‘freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.’
- **Article 10 of CEDAW** provides that women’s right to education includes ‘access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.’
- **The Beijing Platform for Action** states that ‘the human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.’
- **CEDAW General Recommendation No 24:** Article 12 of the Convention (women and health) recommends States parties prioritise the ‘prevention of unwanted pregnancy through family planning and sex education.’
- **CESCR General Comment 14** on Article 12 (the right to the highest attainable standard of health) provides that states parties are required to introduce ‘measures to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information.’
- **CESCR General Comment 22** on Article 12 (the right to sexual and reproductive health) recommends States ‘take affirmative measures to eradicate social barriers in terms of norms or beliefs that inhibit individuals of

different ages and genders, women, girls and adolescents from autonomously exercising their right to sexual and reproductive health’, ‘repeal or reform laws and policies that nullify or impair the ability of certain individuals and groups to realize their right to sexual and reproductive health’, ‘repeal or eliminate laws, policies and practices that criminalize, obstruct or undermine access by individuals or a particular group to sexual and reproductive health facilities, services, goods and information’, ‘States parties must put in place laws, policies and programmes to prevent, address and remediate violations of the right of all individuals to autonomous decision-making on matters regarding their sexual and reproductive health, free from violence, coercion and discrimination’ and that health-care facilities, services, goods, information and programmes related to sexual and reproductive health are available, accessible and respectful.

- **CEDAW General Recommendation No 35:** (on gender-based violence against women, updating general recommendation No. 19) clarifies that ‘Violations of women’s sexual and reproductive health and rights, such as forced sterilizations, forced abortion, forced pregnancy, criminalisation of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.’¹⁷⁰

4.20 While the focus in some of the international human rights commentary has been on reproductive aspects of sexual and reproductive rights, it is important to ensure sexual rights pertaining to sexual identity, expression and experience are also addressed, as WWDA has previously explained:

*Sexual rights guarantee that everyone has access to the conditions that allow fulfilment and expression of their sexualities, free from any coercion, discrimination or violence and within a context respectful of dignity. Sexuality is a central aspect of being human. It encompasses many dimensions that may or may not be experienced or expressed. Sexuality is an evolving concept that encompasses sexual activity, gender identities, sexual orientation, pleasure, eroticism, intimacy and reproduction. Sexuality is experienced and expressed in many ways, including through relationships, attitudes, values, behaviours, practices, beliefs, thoughts, fantasies, and desires. Although sexual and reproductive rights are often inter-related, many expressions of sexuality are non-reproductive and therefore the specificity of sexual rights needs to be understood in its own right, and not automatically subsumed under reproductive rights and reproductive health.*¹⁷¹

4.21 The UN’s articulation of sexual rights (as distinct to the related field of reproductive rights) focuses on three main areas:

- **Sexual orientation and gender identity:** protection from discrimination on grounds of sexual orientation and gender identity; protection of LGBTI people from violence, including torture and cruel, inhuman and degrading treatment; decriminalise homosexuality and repeal other laws used to punish individuals on the basis of sexual orientation and gender identity; and protect the rights of LGBTI persons to freedom of expression, association and assembly and to take part in the conduct of public affairs.¹⁷²
- **Sexual violence as part of gender-based violence:** refrain from committing acts of violence against women on the streets or in custodial settings; abstain from enacting and implementing laws and policies that allow forced sterilization or virginity testing, as well as laws sanctioning forced marriages; exercise due diligence in preventing, punishing and redressing harm caused

by private parties; ensure an enabling environment where violence against women is prevented, and access to legal, health and social services is ensured in cases where violence does occur.¹⁷³

- **Sexual health:** (with a particular focus on HIV/AIDS)¹⁷⁴

- 4.22 This approach to sexual rights is apparent in the CRPD, which generally adopts ‘protective and medical discourses’ and focuses on issues of health and violence rather than approaching human rights as ‘a way of advancing sexual desire, freedom, and self-determination’.¹⁷⁵ While the CRPD does not contain a specific Article on sexuality, WWDA is of the view that human rights in the CRPD and other treaties can be applied to the context of disabled women and girls’ sexual identity, activity and expression, insofar as the more general rights in the CRPD provide many of the necessary conditions for supporting disabled people’s sexual pleasure and self-determination and for avoiding a narrow conception of sexuality as purely about violence and health.¹⁷⁶ We proceed on this basis in the exploration of sexual and reproductive rights below.
- 4.23 We now turn to discuss sexual and reproductive violence in relation to specific human rights, with a particular focus on the CRPD.

Equality and Non-Discrimination

- 4.24 Equality and non-discrimination are among the most fundamental principles and rights of international human rights law. Because they are interconnected with human dignity, they are the cornerstones of all human rights. States Parties have an obligation to respect, protect and fulfil the right of all persons with disabilities to non-discrimination and equality. This means that States Parties must refrain from any action that discriminates against persons with disability. For women and girls with disability to be treated equally to others, live free from sexual and reproductive violence and make meaningful choices about their health, where they live, their mobility, their sexual and reproductive activity, and their social, familial and intimate relationships Australia needs to meet its obligations under Articles 5 and 6 of the CRPD and abolish discriminatory laws that enable and regulate sexual and reproductive violence.
- 4.25 The CRPD codifies a ‘human rights model’ of disability.¹⁷⁷ This model is distinct to a medical or charity model found in earlier human rights instruments pertaining to disability. The UN CRPD Committee explains:
- The human rights model of disability recognizes that disability is a social construct and impairments must not be taken as a legitimate ground for the denial or restriction of human rights. It acknowledges that disability is one of several layers of identity. Hence, disability laws and policies must take the diversity of persons with disabilities into account. It also recognizes that human rights are interdependent, interrelated and indivisible.*¹⁷⁸
- 4.26 This model ‘values impairment as part of human diversity and human dignity.’¹⁷⁹ The inherent dignity of the human being is the focus of the human rights model of disability, rather than any impairment. It ‘clarifies that impairment does not derogate human dignity nor does it encroach upon the disabled person’s status as a rights-bearer.’¹⁸⁰
- 4.27 Equality and non-discrimination are found in the CRPD both as a general principle¹⁸¹ and as a right.¹⁸² The CRPD preamble recognises that ‘discrimination against any person on the basis of disability is a violation of the inherent dignity and worth of the human person’.

4.28 Article 5(2) provides that Governments must prohibit ‘all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.’ ‘Discrimination on the basis of disability’ is defined as: ‘any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.’¹⁸³ ‘Discrimination on all grounds’ is defined as:

*... all possible grounds of discrimination and their intersections must be taken into account. Possible grounds include but are not limited to: disability; health status; genetic or other predisposition towards illness; race; colour; descent; sex; pregnancy and maternity/paternity; civil; family or carer status; gender expression; sex; language; religion; political or other opinion; national, ethnic, indigenous or social origin; migrant, refugee or asylum status; belonging to a national minority; economic or property status; birth; and age, or a combination of any of those grounds or characteristics associated with any of those grounds.*¹⁸⁴

4.29 Relevant to women and girls with disability, Article 2 of CEDAW provides that:

States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:

To refrain from engaging in any act or practice of discrimination against women and to ensure that public authorities and institutions shall act in conformity with this obligation;

To take all appropriate measures to eliminate discrimination against women by any person, organisation or enterprise;

To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women.

4.30 Article 1 of CEDAW defines ‘discrimination against women’ as:

any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.

4.31 Relevant to First Nations women and girls with disability, Article 22 of UN Declaration on the Rights of Indigenous Peoples (UNDRIP) provides that

Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities in the implementation of this Declaration.

States shall take measures, in conjunction with indigenous peoples, to ensure that indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination.

4.32 Other international human rights instruments also protect the right to equality and non-discrimination. Article 26 of the ICCPR provides that:

All persons are equal before the law and are entitled without any discrimination to the

equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground.

4.33 Equality and non-discrimination is also protected by CRC in relation to children and CERD in relation to racial discrimination.

4.34 The UN CRPD Committee in the context of its General Comment 6 (Equality and Non-discrimination) highlights the role of laws – and the paternalism underpinning them – as sustaining inequality and violence against people with disability:

... laws and regulatory frameworks often remain imperfect and incomplete or ineffective, or reflect an inadequate understanding of the human rights model of disability. Many national laws and policies perpetuate the exclusion and isolation of and discrimination and violence against persons with disabilities. They often lack a recognition of multiple and intersectional discrimination or discrimination by association; fail to acknowledge that the denial of reasonable accommodation constitutes discrimination; and lack effective mechanisms of legal redress and reparation. Such laws and policies are commonly not regarded as disability-based discrimination because they are justified as being for the protection or care of the persons with a disability, or in their best interest.¹⁸⁵

4.35 The current UN Special Rapporteur on the Rights of Persons with Disabilities cautions against paternalism slipping into the interpretation of the rights in the CRPD. He has noted in the context of armed conflict, “protection” in the [CRPD] is part of a broader agenda of personhood, inclusion and participation: a vision of active human agency.¹⁸⁶ That is, protection must not slip into paternalism, as he noted:

Protection, as such, has not gone away. It is embraced by the Convention (see art. 16, on freedom from exploitation, violence and abuse). However, it is now shorn of its paternalistic roots. In a way, it is acknowledged in the Convention that there is no such thing as an inherently vulnerable person, but only persons with disabilities placed in vulnerable situations. The need to deal with this imposed vulnerability is therefore highlighted. ... An end to impunity is also demanded in article 16. Accordingly, the historic invisibility of persons with disabilities in law enforcement is acknowledged and its reversal sought.

The Convention therefore does not eliminate the need for protection, but places it on fundamentally different predicates. This has clear implications for laws and policies along the peace continuum that seem to overemphasize the medical condition of disability and downplay the moral agency of persons with disabilities, as well as the broader skein of rights into which protection should be understood.¹⁸⁷

4.36 While ableism is not mentioned in the CRPD, the former UN Special Rapporteur on the Rights of Persons with Disabilities, discusses the role of ableism in discrimination and inequality. The former UN Special Rapporteur on the Rights of Persons with Disabilities defines ‘ableism’ as:

... a value system that considers certain typical characteristics of body and mind as essential for living a life of value. Based on strict standards of appearance, functioning and behaviour, ableist ways of thinking consider the disability experience as a misfortune that leads to suffering and disadvantage and invariably devalues human life.¹⁸⁸

4.37 She explains that ableism lies:

... at the root of discriminatory practices, such as the sterilization of girls and women

with disabilities, the segregation, institutionalization and deprivation of liberty of persons with disabilities in disability-specific facilities and the use of coercion on the basis of “need of treatment” or “risk to self or to others,” the denial of legal capacity on the basis of mental capacity, the denial of treatment on the basis of disability, or the failure to consider the extra costs of living with a disability.¹⁸⁹

- 4.38 The former UN Special Rapporteur on the Rights of Persons with Disabilities draws on the principle in the CRPD of inherent dignity to re-assert the entitlement of people with disability to full humanity:

Life with a disability is a life worth living equal to others. Every person has a unique set of unrepeatable characteristics and experiences that make them irreplaceable and valuable. The lives of persons with disabilities are human lives and, consequently, endowed with inherent dignity. Persons with disabilities can live fulfilling lives and enjoy what gives life meaning.¹⁹⁰

- 4.39 She argues that addressing ableism is not simply about ‘awareness raising’, but rather requires ‘cultural transformation’:

Given the cultural and societal challenges posed by ableism, neither awareness-raising programmes nor the generalization of anti-discrimination measures will alone suffice. What is needed is a cultural transformation of the way society relates to the difference of disability. That is a commitment to the recognition of persons with disabilities as equals on all terms, with the same rights and opportunities as everyone else in society. It is thus vital to reduce the distance between society’s views of disability and the narratives of those living with a disability. The devaluation of the lives of persons with disabilities comes partly from a historic inability to listen to what persons with disabilities have to say about themselves.¹⁹¹

- 4.40 Article 5(1) provides for the right to be equal before and under the law, which means people with disability ‘have the right to be effectively protected and to positively engage.’¹⁹² Laws that discriminate against people with disability violate Article 5(1) such that ‘there should be no laws that allow for specific denial, restriction or limitation of the rights of persons with disabilities, and that disability should be mainstreamed in all legislation and policies.’¹⁹³ The right to ‘equal protection under the law’ is particularly significant in the context of substituted decision-making and compulsory treatment laws that treat people with disability unequally. The UN CRPD Committee states that ‘deprivation of liberty; torture or cruel, inhuman or degrading treatment or punishment; violence; and the forced treatment of persons with disabilities inside and outside of mental health facilities are ‘by definition discriminatory.’¹⁹⁴

- 4.41 States Parties obligations in relation to equality and non-discrimination extend to the abolition of discriminatory laws, such as those that enable forced and/or coerced sterilisation. As the UN CRPD Committee states:

States parties shall modify or abolish existing laws, regulations, customs and practices that constitute such discrimination. The Committee has often given examples in that regard including: guardianship laws and other rules infringing upon the right to legal capacity; mental health laws that legitimize forced institutionalization and forced treatment, which are discriminatory and must be abolished; non-consensual sterilization of women and girls with disabilities; inaccessible housing and institutionalization policy; segregated education laws and policies; and election laws that disenfranchise persons with disabilities.¹⁹⁵

- 4.42 As well as abolishing discriminatory laws, in implementing Article 5, States Parties are also required to: ‘[e]stablish accessible and effective redress mechanisms and ensure access to justice, on an equal basis with others, for victims of discrimination based on disability.’¹⁹⁶

- 4.43 Through CRPD General Comment 6 (Equality and non-discrimination) the UN CRPD Committee has provided authoritative guidance on the implementation of, and intersection between other CRPD Articles including 12, 14, 15, 16, 17 and 19 and CRPD Article 5 (Equality and non-discrimination). The Committee has clarified for example, that:

Persons with disabilities can be disproportionately affected by violence, abuse and other cruel and degrading punishment, which can take the form of restraint or segregation as well as violent assault. The Committee is particularly concerned about the following acts committed against persons with disabilities, including children on the grounds of impairment, which by definition are discriminatory: separation of children with disabilities from their families and forced placement in institutions; deprivation of liberty; torture or cruel, inhuman or degrading treatment or punishment; violence; and the forced treatment of persons with disabilities inside and outside of mental health facilities. States parties must take all appropriate measures, to provide protection from and prevent all forms of exploitation, violence and abuse against persons with disabilities. Forced corrective disability treatments should be prohibited.¹⁹⁷

- 4.44 Intersectionality is a key element of the human rights approach to disability required by the CRPD. The CRPD explicitly acknowledges different layers or intersections of discrimination, through paragraph (p) of its preamble:

Concerned about the difficult conditions faced by persons with disabilities who are subject to multiple and aggravated forms of discrimination on the basis of race, colour, sex, language, religion, political or other opinion, national, ethnic, indigenous or social origin, property, birth, age or other status.

- 4.45 Women and girls with disability are among those groups of persons with disability who most often experience multiple and intersectional discrimination. As the UN CRPD Committee observes:

There is strong evidence to show that women and girls with disabilities face barriers in most areas of life. These barriers create situations of multiple and intersecting forms of discrimination against women and girls with disabilities, in particular with regard to: equal access to education, economic opportunities, social interaction and justice; equal recognition before the law; and the ability to participate in politics and to exercise control over their own lives across a range of contexts, for example with regard to health care, including sexual and reproductive health services, and to where and with whom they wish to live.¹⁹⁸

- 4.46 Article 5 is complemented by Article 6 of the CRPD which is a binding equality and non-discrimination article that prohibits discrimination against women and girls with disabilities, obliging States Parties to promote equality of both opportunity and outcomes. Article 6 recognises ‘that women and girls with disabilities are subject to multiple discrimination’,¹⁹⁹ which establishes ‘the first binding intersectionality clause in a human rights treaty.’²⁰⁰

- 4.47 In its General Comment 3 (Women and Girls with Disabilities), the UN CRPD Committee recognises that the discrimination women and girls with disability experience can constitute ‘structural discrimination’:

Structural, or systemic, discrimination is reflected in hidden or overt patterns of discriminatory institutional behaviour, discriminatory cultural traditions and discriminatory social norms and/or rules. Harmful gender and disability stereotyping, which can lead to such discrimination, is inextricably linked to a lack of policies, regulations and services specifically for women with disabilities. For example, owing

to stereotyping based on the intersection of gender and disability, women with disabilities may face barriers when reporting violence, such as disbelief and dismissal by the police, prosecutors and courts. ... The lack of awareness, training and policies to prevent harmful stereotyping of women with disabilities by public officials, be they teachers, health service providers, police officers, prosecutors or judges, and by the public at large can often lead to the violation of rights.²⁰¹

- 4.48 General Comment 3 (Women and Girls with Disabilities) specifically recognises that women and girls with disability are more likely to be discriminated against than men and boys with disability and women and girls without disability.²⁰² This General Comment highlights that women and girls with disability experience the ‘same harmful practices’²⁰³ committed against women without disability but also experience specific and unique forms of violence. This includes: the absence of free and informed consent and legal compulsory detention and treatment; economic exploitation; violations of sexual and reproductive rights; and forms of violence that constitute torture and ill-treatment, such as forced or coerced sterilisation, the administration of electroshock treatment and the use of chemical, physical or mechanical restraints, and isolation and seclusion.²⁰⁴
- 4.49 Article 6 is a cross-cutting article that relates to all other articles of the CRPD.²⁰⁵ This means that the issues and concerns of women and girls with disability must be included in all actions to implement the CRPD, including the implementation of ‘positive measures... to ensure that women with disabilities are protected against multiple discrimination and can enjoy human rights and fundamental freedoms on an equal basis with others.’²⁰⁶
- 4.50 Article 6 ensures that the CRPD is not gender neutral, and this is reinforced by other elements within the CRPD:
- Preamble paragraph (s) states, ‘[e]mphasising the need to incorporate a gender perspective in all efforts to promote the full enjoyment of human rights and fundamental freedoms by persons with disabilities’;
 - Article 3(g) contains the principle ‘Equality between men and women’; and
 - Specific ‘sex’, ‘gender’ and ‘age’ references are included throughout the CRPD.²⁰⁷
- 4.51 General Comment 3 (Women and Girls with Disabilities) clarifies that Article 6 is a binding non-discrimination and equality provision that unequivocally obligates Governments to outlaw discrimination against women with disability and promotes equality of opportunity and equality of outcomes. In General Comment 3 the UN CRPD Committee recognises the significant barriers encountered by women and girls with disability, including in relation to sexual and reproductive health:

There is strong evidence to show that women and girls with disabilities face barriers in most areas of life. These barriers create situations of multiple and intersecting forms of discrimination against women and girls with disabilities, particularly, with regard to equal access to education, access to economic opportunities, access to social interaction, access to justice and equal recognition before the law, the ability to participate politically, and the ability to exercise control over their own lives across a range of contexts, for example: with regard to healthcare, including sexual and reproductive health; and where and with whom they wish to live.²⁰⁸

- 4.52 In order to combat multiple discrimination against women and girls with disability, States Parties must abolish laws and introduce other laws:

Repealing discriminatory laws, policies and practices that prevent women with disabilities from enjoying all the rights enshrined in the Convention, outlawing gender-

and disability-based discrimination and its intersectional forms, criminalizing sexual violence against girls and women with disabilities, prohibiting all forms of forced sterilization, forced abortion and non-consensual birth control, prohibiting all forms of forced gender- and/or disability-related medical treatment and taking all appropriate legislative steps to protect women with disabilities against discrimination.

Adopting appropriate laws, policies and actions to ensure that the rights of women with disabilities are included in all policies, especially in policies related to women in general and policies on disability.²⁰⁹

- 4.53 The UN CRPD Committee also emphasises the importance of recognising and addressing stigma and stereotypes pertaining to women with disability, even though they might seem ‘benign’:

Ensuring the human rights of women requires, first and foremost, a comprehensive understanding of the social structures and power relations that frame laws and policies, as well as of economic and social dynamics, family and community life, and cultural beliefs. Gender stereotypes can limit women’s capacity to develop their own abilities, pursue professional careers and make choices about their lives and life plans. Both hostile/negative and seemingly benign stereotypes can be harmful. Harmful gender stereotypes need to be recognized and addressed in order to promote gender equality. The Convention enshrines an obligation to combat stereotypes, prejudices and harmful practices relating to persons with disabilities, including those based on sex and age, in all areas of life.²¹⁰

- 4.54 In a joint statement, published in 2018, the UN CRPD Committee and the United Nations Committee on the Convention on the Elimination of All Forms of Discrimination Against Women (UN CEDAW Committee) observe the interrelationship of gender and disability equality in the context of sexual and reproductive health:

The Committees recall that gender equality and disability rights are mutually reinforcing concepts and States parties should guarantee the human rights of all women, including women with disabilities. As such, States parties have an obligation to respect, protect and fulfill the rights of women, including women with disabilities, in relation to their sexual and reproductive health and rights. States must ensure the enjoyment of their sexual and reproductive health and rights without any form of discrimination. Access to safe and legal abortion, as well as related services and information are essential aspects of women’s reproductive health and a prerequisite for safeguarding their human rights to life, health, equality before the law and equal protection of the law, non-discrimination, information, privacy, bodily integrity and freedom from torture and ill treatment.²¹¹

- 4.55 The importance of ageism in relation to older women with disability warrants further attention. The former UN Special Rapporteur on the Rights of Persons with Disabilities explains ageism and ableism as follows:

Although ageism and ableism share common roots and consequences, inequality in older age is not the mere result of ableist biases. Ageism – the stereotyping of, and prejudice and discrimination towards, older people and older age – is a distinct form of oppression that affects older persons, including older persons with disabilities. Older persons are often perceived as a burden, dependent, unproductive, undeserving or helpless. While disability is increasingly understood as a social construct, inequalities due to old age are predominantly seen as “natural” or “inevitable.” Therefore, older persons with disabilities are discriminated against and disadvantaged not just because they have a disability, but also because of stereotypes about older people.²¹²

4.56 She notes that older women with disability are particularly impacted:

Older women with disabilities have consistently worse life prospects and outcomes than older women without disabilities and older men with disabilities. Gender roles and expectations often push these women into economic dependency. As a result, older women with disabilities are considerably poorer; are likely to be subject to violence, abuse and neglect; and have higher chances of facing unmet needs and human rights violations. In addition, older women with disabilities are more likely to be institutionalized or incapacitated owing to the higher life expectancy of women compared with men.²¹³

4.57 The former UN Special Rapporteur on the Rights of Persons with Disabilities identifies a number of human rights challenges affecting older persons with disabilities: ‘stigma and stereotypes; direct and indirect discrimination; denial of autonomy and legal capacity; institutionalization and lack of community support; violence and abuse; and lack of adequate social protection.’²¹⁴

4.58 The former UN Special Rapporteur on the Rights of Persons with Disabilities notes that violence, including physical, psychological and sexual abuse, caregiver neglect and financial exploitation, is another key human rights issue for older persons with disability.²¹⁵ This is particularly significant in ‘long-term care’ contexts.²¹⁶

Equal Recognition Before the Law

4.59 Laws that regulate restrictive practices and other coercive interventions that enable sexual and reproductive violence, including substituted decision-making and compulsory treatment laws, violate the right to equal recognition before the law. Governments are required to abolish discriminatory laws that enable coercive interventions and to introduce supported decision-making laws that enable people with disability to have their choices about their bodies and lives legally recognised. From this perspective, the question is no longer ‘does this individual have mental capacity and thus legal capacity’ but rather ‘what support does this individual need to realise their universal legal capacity’.

4.60 Article 12 of the CRPD provides that Governments: ‘reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law’; ‘shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life’; ‘shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity’; and ‘shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law.’

4.61 In a similar vein (although not engaged with the specific challenges and injustices encountered by people with disability), Article 16 of the ICCPR provides that: ‘Everyone shall have the right to recognition everywhere as a person before the law’.

4.62 Article 12 of the CRPD is premised on the CRPD’s general principles, namely: respect for the inherent dignity, individual autonomy (including the freedom to make one’s own choices), and independence of persons; non-discrimination; full and effective participation and inclusion in society; respect for difference and acceptance of persons with disability as part of human diversity and humanity; equality of opportunity; accessibility; equality between men and women; and respect for the evolving capacities of children with disability and respect for the right of children with disability to preserve their identities.

4.63 The effect of Article 12 is to recognise universal legal capacity and focus on the provision

of support to ensure people with disability have their decisions legally recognised and are not abused in the course of exercising their legal capacity. As explained by the UN CRPD Committee, ‘Article 12 does not permit such discriminatory denial of legal capacity, but, rather, requires that support be provided in the exercise of legal capacity.’²¹⁷ The right to equal recognition before the law implies that legal capacity is a universal attribute inherent in all persons by virtue of their humanity and must be upheld for persons with disability on an *equal basis with others*. The UN CRPD Committee acknowledges the problematic nature of ‘mental capacity’, being the basis on which legal capacity is conventionally denied:

*The concept of mental capacity is highly controversial in and of itself. Mental capacity is not, as is commonly presented, an objective, scientific and naturally occurring phenomenon. Mental capacity is contingent on social and political contexts, as are the disciplines, professions and practices which play a dominant role in assessing mental capacity.*²¹⁸

- 4.64 Legal capacity underpins personhood,²¹⁹ and is central to the realisation of other human rights, as noted by the UN CRPD Committee:

*The right to legal capacity is a threshold right, that is, it is required for the enjoyment of almost all other rights in the Convention, including the right to equality and non-discrimination.*²²⁰

- 4.65 The UN CRPD Committee identifies discriminatory laws as central to denial of legal capacity to people with disability:

*States parties must holistically examine all areas of law to ensure that the right of persons with disabilities to legal capacity is not restricted on an unequal basis with others. Historically, persons with disabilities have been denied their right to legal capacity in many areas in a discriminatory manner under substitute decision-making regimes such as guardianship, conservatorship and mental health laws that permit forced treatment. These practices must be abolished in order to ensure that full legal capacity is restored to persons with disabilities on an equal basis with others.*²²¹

- 4.66 The UN CRPD Committee states that abolishing laws that deny legal capacity is central to realisation of Article 12: ‘In order to fully recognize “universal legal capacity,” whereby all persons, regardless of disability or decision-making skills, inherently possess legal capacity, States parties must abolish denials of legal capacity that are discriminatory on the basis of disability in purpose or effect.’²²² Thus, in implementing Article 12, States Parties should:

*Recognize persons with disabilities as persons before the law, having legal personality and legal capacity in all aspects of life, on an equal basis with others. This requires the abolition of substitute decision-making regimes and mechanisms that deny legal capacity and which discriminate in purpose or effect against persons with disabilities.*²²³

- 4.67 The UN CRPD Committee has made it clear that Governments’ obligation to replace substitute decision-making regimes by supported decision-making requires both abolition of substitute decision-making regimes and development of supported decision-making alternatives.²²⁴ Support in the exercise of legal capacity must respect the rights, will and preferences of persons with disability and should never amount to substitute decision-making. Importantly, abolition must occur simultaneously to the introduction and development of supported decision-making:

States parties’ obligation to replace substitute decision-making regimes by supported decision-making requires both the abolition of substitute decision-making regimes

*and the development of supported decision-making alternatives. The development of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12 of the Convention.*²²⁵

4.68 The UN CRPD Committee recognises forced psychiatric, medical and health treatment as a violation of the right to equal recognition before the law because '[t]his practice denies the legal capacity of a person to choose medical treatment.' Instead, Governments are required to 'respect the legal capacity of persons with disabilities to make decisions at all times, including in crisis situations' and provide them with accessible information and supports to make decisions.²²⁶ States Parties must abolish policies and legislative provisions that allow or perpetrate forced treatment, as it is an ongoing violation found in mental health laws across the globe, despite empirical evidence indicating its lack of effectiveness and the views of people using mental health systems who have experienced deep pain and trauma as a result of forced treatment. The UN CRPD Committee recommends that States Parties ensure that decisions relating to a person's physical or mental integrity can only be taken with the free and informed consent of the person concerned.²²⁷

4.69 In relation to older people with disability, who might be considered to 'naturally' relinquish their legal capacity as they age, the former Special Rapporteur on the Rights of Persons with Disabilities has stated that:

*Having high support needs cannot justify the denial of autonomy and legal capacity. Loss of autonomy is not a natural process, but a social process that results from the failure of society to respect and support the will and preferences of all people. Older persons with disabilities have the right to maintain their legal capacity and to have access to supported decision-making, and their agency needs to be recognized and facilitated. Furthermore, all health and social care services should be based on the free and informed consent of the individual concerned, and all laws that allow involuntary treatment or placement in residential care upon the authorization of third parties, such as family members, or on the basis of an actual or perceived mental health condition or other impairment, should be repealed.*²²⁸

4.70 The UN CRPD Committee recognises that women with disability are subject to multiple and intersectional forms of discrimination and thus are more likely to be denied their right to legal capacity. This has significant impacts on other rights – including the right to maintain sexual and reproductive autonomy, to found and maintain a family, to choose where and with whom to live, to be free from violence, to maintain bodily and mental integrity, and to realise their right to work in the open labour market, in work that is freely chosen, and that provides just, favourable conditions of work on an equal basis with others.²²⁹ It recognises that:

*[r]estricting or removing legal capacity can facilitate forced interventions, such as sterilization, abortion, contraception, female genital mutilation, surgery or treatment performed on intersex children without their informed consent and forced detention in institutions.*²³⁰

Moreover, it notes that:

*[f]orced contraception and sterilization can also result in sexual violence without the consequence of pregnancy, especially for women with psychosocial or intellectual disabilities, women in psychiatric or other institutions and women in custody.*²³¹

4.71 Many women and girls with disability are not afforded the right to make their own decisions because others determine that they 'lack capacity' to do so. Such judgements often lead

to substitute decision-making processes whereby others decide, on behalf of a woman or girl, what is in her ‘best interest.’ This is particularly the case for women and girls with intellectual disability – where the diagnosis of intellectual disability is assumed to equate with a lack of capacity to make decisions.²³² Substitute decision-making and ‘best interest’ approaches have been thoroughly criticised as fundamentally contravening the CRPD and as intrinsically value-laden.²³³ In practice, the ‘best interest’ approach most often serves the interests of guardians, families, carers and service providers.²³⁴ As stated by Professor Ian Kennedy:

*The best interests formula may be beloved of family lawyers but a moment’s reflection will indicate that although it is said to be a test, indeed the legal test for deciding matters relating to children, it is not really a test at all. Instead, it is a somewhat crude conclusion of social policy. It allows lawyers and courts to persuade themselves and others that theirs is a principled approach to law. Meanwhile, they engage in what to others is clearly a form of ‘ad hocery’.*²³⁵

- 4.72 In its General Comment 3 (Women and Girls with Disabilities), the UN CRPD Committee explains how denial of legal capacity enables violence:

In practice, the choices of women with disabilities, especially women with psychosocial or intellectual disabilities are often ignored, their decisions are often substituted by third parties, including legal representatives, service providers, guardians and family members, thus violating their rights under article 12. All women with disabilities must be able to exercise their legal capacity by taking their own decisions, with support when desired with regard to medical and/or therapeutic treatment, including decisions on: retaining their fertility, reproductive autonomy, their right to choose the number and spacing of children, to consent and accept a statement of fatherhood, and the right to establish relationships. Restricting or removing legal capacity can facilitate forced interventions, such as: sterilisation, abortion, contraception, female genital mutilation, or surgery, or treatment performed on intersex children without their informed consent and forced detention in institutions.

*Forced contraception and sterilization can also result in sexual violence without the consequence of pregnancy, especially for women with psychosocial or intellectual disabilities and those in psychiatric or other institutions or custody. Therefore, it is particularly important to reaffirm that the legal capacity of women with disabilities should be recognised on an equal basis with others, that women with disabilities have the right to found a family and be provided with appropriate assistance to raise their children.*²³⁶

- 4.73 In their 2018 joint statement, the UN CRPD Committee and the United Nations Committee on the Convention on the Elimination of All Forms of Discrimination Against Women (UN CEDAW Committee) state the importance of autonomy in sexual and reproductive health:

States parties should ensure non-interference, including by non-State actors, with the respect for autonomous decision-making by women, including women with disabilities, regarding their sexual and reproductive health well-being. A human rights-based approach to sexual and reproductive health acknowledges that women’s decisions on their own bodies are personal and private, and places the autonomy of the woman at the center of policy and law-making related to sexual and reproductive health services, including abortion care. States should adopt effective measures to enable women, including women with disabilities, to make autonomous decisions about their sexual and reproductive health and should ensure that women have access to evidence-based and unbiased information in this regard. It is also critical that these decisions are made freely and that all women, including women with disabilities, are protected against forced abortion, contraception or sterilization against their will or

*without their informed consent. Women should neither be stigmatized for voluntarily undergoing abortion nor forced to undergo an abortion or sterilization against their will or without their informed consent.*²³⁷

Freedom from Violence

4.74 Freedom from violence is a significant thread running through a number of Articles in the CRPD. Freedom from violence is a right in itself. Moreover, related to rights to equality and non-discrimination, States Parties ensure people with disability have other rights – to liberty and security of person, freedom from torture, and personal integrity – protected on an equal basis to others, with the violation of these rights giving rise to violence. Thus, the CRPD is premised on recognition of a strong connection between discrimination and violence. For women and girls with disability to be free from violence, including sexual and reproductive violence, Australia needs to meet its obligations under a broad range of CRPD Articles (16, as well as 14, 15, 17 in conjunction with 5, 6 and 12) in order to abolish laws and practices that give rise to unlawful violations, as well those violations that are discriminatory and lawful.

Freedom from Violence, Abuse, Neglect and Exploitation

- 4.75 Article 16 of the CRPD requires Governments: (a) ‘protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects’; (b) ‘prevent all forms of exploitation, violence and abuse’; (c) ‘promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse’; and (d) ‘put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.’
- 4.76 Freedom from violence is also protected by Article 19 of CRC which provides that ‘States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child’. Article 39 of CRC provides that States Parties must ‘take all appropriate measures to promote physical and psychological recovery and social reintegration’ of a child victim of neglect, exploitation, abuse, and torture or any other form of cruel, inhuman or degrading treatment or punishment.
- 4.77 In relation to women and girls with disability, the UN CRPD Committee has defined violence as being ‘interpersonal’ or ‘institutional and/or structural violence.’ The latter is defined as ‘any form of structural inequality or institutional discrimination that keeps a woman in a subordinate position, whether physically or ideologically, compared with other people in her family, household or community’.²³⁸
- 4.78 According to the UN CRPD Committee, specific examples of violence against women and girls with disability that will violate Article 16 include those relevant to sexual and reproductive violence: ‘the absence of free and informed consent and legal compulsion’; ‘the refusal by caregivers to assist with daily activities such as bathing, menstrual and/or sanitation management, dressing and eating’; ‘the withholding of food or water’; and ‘the exercise of control, for example by restricting face-to-face or virtual access to family, friends

or others.’²³⁹ It also extends to sexual violence, noting that: ‘Some women with disabilities, in particular deaf and deafblind women and women with intellectual disabilities, may be at an even greater risk of violence and abuse because of their isolation, dependency or oppression.’²⁴⁰ Moreover, ‘[w]omen with disabilities may be targeted for economic exploitation because of their impairment, which can in turn expose them to further violence.’²⁴¹

- 4.79 Certain forms of violence (relevant to restrictive practices) can constitute ‘cruel, inhuman or degrading treatment or punishment and as breaching a number of international human rights treaties’, including:

*forced, coerced and otherwise involuntary pregnancy or sterilization; any medical procedure or intervention performed without free and informed consent, including procedures and interventions related to contraception and abortion; invasive and irreversible surgical practices such as psychosurgery, female genital mutilation and surgery or treatment performed on intersex children without their informed consent; the administration of electroshock treatment and the use of chemical, physical or mechanical restraints; and isolation or seclusion.*²⁴²

- 4.80 The UN CRPD Committee notes that enjoying freedom from violence can be hindered by harmful stereotypes about women and girls with disability: ‘Harmful stereotypes that infantilize women with disabilities and call into question their ability to make judgements, perceptions of women with disabilities as being asexual or hypersexual’.²⁴³

Liberty

- 4.81 Depriving people with disability of their liberty, including through restrictive practices and involuntary mental health detention, violates the right to liberty on an equal basis with others and facilitates sexual and reproductive violence.
- 4.82 Article 14 of the CRPD provides that Governments shall ensure that persons with disabilities, ‘on an equal basis with others’, ‘enjoy the right to liberty and security of person’ and ‘are not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.’
- 4.83 The UN CRPD Committee, in summarising its jurisprudence on Article 14, has stated that it requires ‘absolute prohibition of detention on the basis of disability.’²⁴⁴
- 4.84 In a similar, but more general vein, Article 9 of the ICCPR provides: ‘Everyone has the right to liberty and security of person’. Specifically in relation to First Nations people, Article 7 of DRIP provides that: ‘Indigenous individuals have the rights to life, physical and mental integrity, liberty and security of person’.
- 4.85 The UN CRPD Committee in its General Comment 3 (Women and Girls with Disabilities) has noted that women and girls with disability can be exposed to sexual violence whilst deprived of their liberty in institutional settings:

Violations relating to deprivation of liberty disproportionately affect women with intellectual or psychosocial disabilities and those in institutional settings. Those deprived of their liberty in places such as psychiatric institutions, on the basis of actual or perceived impairment, are subject to higher levels of violence, as well as to cruel, inhuman or degrading treatment or punishment and are segregated and exposed to the risk of sexual violence and trafficking within care and special

education institutions. Violence against women with disabilities in institutions includes: involuntary undressing by male staff against the will of the woman concerned; forced administration of psychiatric medication; and overmedication, which can reduce the ability to describe and/or remember sexual violence. Perpetrators may act with impunity because they perceive little risk of discovery or punishment given that access to judicial remedies is severely restricted, and women with disabilities subjected to such violence are unlikely to be able to access helplines or other forms of support to report such violations.²⁴⁵

Personal Integrity

- 4.86 Article 17 of the CRPD provides that '[e]very person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.'
- 4.87 Article 7 of DRIP specifically provides that Indigenous individuals 'have the rights to life, physical and mental integrity, liberty and security of person'.
- 4.88 The UN CRPD Committee has stated in its General Comment 3 (Women and Girls with Disabilities) that '[w]omen with disabilities are more likely to be subjected to forced interventions than are women in general and men with disabilities' and these interventions 'are wrongfully justified by theories of incapacity and therapeutic necessity, are legitimized under national laws and may enjoy wide public support for being in the alleged best interest of the person concerned.' However, it states that such forced interventions 'violate the right to personal integrity.'²⁴⁶

Freedom from Torture

- 4.89 Persons with disability have the right to be free from torture, along with cruel, inhuman and degrading treatment.
- 4.90 Article 15 of the CRPD provides that '[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment' and that 'States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.'
- 4.91 The right to torture is also recognised in other international human rights treaties. For example, Article 17 of the ICCPR provides in part that: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment'. Pursuant to Article 37 of CRC, States Parties must ensure that: 'No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment'.
- 4.92 The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) places obligations on States Parties in relation to prevention and redress of torture and cruel, inhuman or degrading treatment or punishment, and monitoring of places of detention where such violations might take place. Article 2 of the CAT provides that: 'Each State Party shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.' There are no exceptions to this: 'No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture.' Moreover, pursuant to Article 4 of the CAT, States Parties need to criminalise 'all acts of torture' and undertake to prevent 'other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture ... when such acts are

committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity’.

- 4.93 The former UN Special Rapporteur on the Rights of Persons with Disabilities provides examples of torture and cruel, inhuman and degrading treatment, including some relevant to sexual and reproductive violence: ‘forced sterilization, contraception and abortion’ and ‘the use of chemical, physical or mechanical restraints’.²⁴⁷
- 4.94 The former Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (‘Special Rapporteur on Torture’) identifies forms of sexual and reproductive violence as forms of torture:

*Some women may experience multiple forms of discrimination on the basis of their sex and other status or identity. Targeting ethnic and racial minorities, women from marginalized communities and women with disabilities for involuntary sterilization because of discriminatory notions that they are “unfit” to bear children is an increasingly global problem. Forced sterilization is an act of violence, a form of social control, and a violation of the right to be free from torture and other cruel, inhuman, or degrading treatment or punishment. The mandate has asserted that “forced abortions or sterilizations carried out by State officials in accordance with coercive family planning laws or policies may amount to torture”.*²⁴⁸

- 4.95 The Special Rapporteur on Torture has also described as torture or ill-treatment ‘medical treatments of an intrusive and irreversible nature, when lacking a therapeutic purpose [and] when enforced or administered without the free and informed consent of the person concerned’, ‘notwithstanding claims of good intentions or medical necessity.’²⁴⁹ He calls for an absolute ban on all forced and non-consensual medical interventions against persons with disabilities, including: ‘the non-consensual administration of psychosurgery, electroshock and mind-altering drugs such as neuroleptics’;²⁵⁰ ‘all coercive and non-consensual measures, including restraint and solitary confinement of people with psychological or intellectual disabilities, ... in all places of deprivation of liberty, including in psychiatric and social care institutions’;²⁵¹ and the ‘institutionalisation of persons with disabilities on the grounds of their disability without their free and informed consent.’²⁵²
- 4.96 As highlighted earlier, the CEDAW Committee has clarified, through General Recommendation No 35: (on gender-based violence against women, updating general recommendation No. 19) that:

‘Violations of women’s sexual and reproductive health and rights, such as forced sterilizations, forced abortion, forced pregnancy, criminalisation of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.’

- 4.97 The prohibition of torture is an ‘absolute and non-derogable human right’, such that scarce financial resources cannot justify postponement of its implementation.²⁵³
- 4.98 These obligations in relation to torture are important, because they highlight that forms of sexual and reproductive violence that amount to torture (such as sterilisation) must be prohibited, and it is not acceptable to simply legally regulate them or minimise or reduce the frequency of their perpetration.

Justice and Redress

4.99 As well as ensuring non-discrimination and equality and prevention of violence and torture, States Parties are also required to provide access to justice processes, as well as access to support and redress in response to violence.

4.100 Article 16 of the CRPD provides in part that States Parties must support recovery, rehabilitation and social reintegration of victims-survivors of violence and also ensure in appropriate circumstances that violence is investigated and prosecuted:

States Parties shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of persons with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs.

States Parties shall put in place effective legislation and policies, including women- and child-focused legislation and policies, to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

4.101 Similarly, but specifically in relation to torture, the Article 14 of the CAT provides that each State Party ‘shall ensure in its legal system that the victim of an act of torture obtains redress and has an enforceable right to fair and adequate compensation, including the means for as full rehabilitation as possible’. The Committee Against Torture has explained that conduct that amounts to torture or ill-treatment gives rise to a duty to provide remedy and reparation.²⁵⁴ The right to redress includes restitution, compensation, rehabilitation, satisfaction, guarantees of non-repetition and the right to truth.²⁵⁵

4.102 As well as providing just outcomes in terms of redress and victim support, States Parties must also provide accessible justice processes. Pursuant to Article 13 of the CRPD States Parties must also ‘ensure effective access to justice for persons with disabilities on an equal basis with others’. The UN CRPD Committee in its General Comment 3 (Women and Girls with Disabilities) explains that women with disabilities face barriers in accessing justice in relation to violence:

due to harmful stereotypes, discrimination and lack of procedural and reasonable accommodations, which can lead to their credibility being doubted and their accusations being dismissed. Procedures or enforcement attitudes may intimidate victims or discourage them from pursuing justice. These can include: complicated or degrading reporting procedures; referral of victims to social services rather than legal remedies; dismissive attitudes by police or other enforcement agencies. This can lead to impunity and invisibility of the issue, resulting in violence lasting for extended periods of time. Women with disabilities may also fear reporting violence, exploitation or abuse because they are concerned they may lose their support requirements from caregivers.²⁵⁶

4.103 The International Principles and Guidelines on Access to Justice for Persons with Disabilities provide 10 principles:

Principle 1: All persons with disabilities have legal capacity and, therefore, no one shall be denied access to justice on the basis of disability.

Principle 2: Facilities and services must be universally accessible to ensure equal access to justice without discrimination of persons with disabilities.

Principle 3: Persons with disabilities, including children with disabilities, have the right to appropriate procedural accommodations.

Principle 4: Persons with disabilities have the right to access legal notices and information in a timely and accessible manner on an equal basis with others.

Principle 5: Persons with disabilities are entitled to all substantive and procedural safeguards recognized in international law on an equal basis with others, and States must provide the necessary accommodations to guarantee due process.

Principle 6: Persons with disabilities have the right to free or affordable legal assistance.

Principle 7: Persons with disabilities have the right to participate in the administration of justice on an equal basis with others.

Principle 8: Persons with disabilities have the rights to report complaints and initiate legal proceedings concerning human rights violations and crimes, have their complaints investigated and be afforded effective remedies.

Principle 9: Effective and robust monitoring mechanisms play a critical role in supporting access to justice for persons with disabilities.

Principle 10: All those working in the justice system must be provided with awareness-raising and training programmes addressing the rights of persons with disabilities, in particular in the context of access to justice.²⁵⁷

- 4.104 The International Principles and Guidelines provide in relation to Guideline 8 that States Parties should ensure that ‘effective remedies are in place for human rights violations, including the right to be free from disability-based discrimination and the rights to restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition’. These remedies should be ‘enforceable, individualized and tailored to meet the needs of claimants’, ‘[e]nsure that victims are protected from repeat violations of their human rights’, and ‘[a]ddress the systemic nature of human rights violations’.²⁵⁸
- 4.105 The ‘*Basic Principles and Guidelines on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law*’ (‘Van Boven Principles’) also provide guidance on redress and support for victims-survivors of violence that constitute gross violations of human rights. In general, the ‘obligation to respect, ensure respect for and implement international human rights law’ includes the duty to:
- (a) Take appropriate legislative and administrative and other appropriate measures to prevent violations;
 - (b) Investigate violations effectively, promptly, thoroughly and impartially and, where appropriate, take action against those allegedly responsible in accordance with domestic and international law;
 - (c) Provide those who claim to be victims of a human rights or humanitarian law violation with equal and effective access to justice, as described below, irrespective of who may ultimately be the bearer of responsibility for the violation; and

(d) Provide effective remedies to victims, including reparation, as described below.²⁵⁹

4.106 Specifically the Van Boven Principles provide that remedies for gross human rights violations include the victim's right to 'equal and effective access to justice'; 'adequate, effective and prompt reparation for harm suffered'; and 'access to relevant information concerning violations and reparation mechanisms'. 'Reparation for harm suffered' 'should be proportional to the gravity of the violations and the harm suffered'.²⁶⁰ Victims of gross violations of international human rights law should 'be provided with full and effective reparation'.²⁶¹ The forms of reparations provided by the Van Boven Principles consist of:

- (a) **Restitution:** This 'should, whenever possible, restore the victim to the original situation before the gross violations of international human rights law or serious violations of international humanitarian law occurred'. Examples of restitution are 'restoration of liberty, enjoyment of human rights, identity, family life and citizenship, return to one's place of residence, restoration of employment and return of property'.
- (b) **Compensation:** This should be 'provided for any economically assessable damage, as appropriate and proportional to the gravity of the violation and the circumstances of each case'. The damage can include: 'physical or mental harm', 'lost opportunities', including employment, education and social benefits, 'material damages and loss of earnings, including loss of earning potential', and 'moral damage'.
- (c) **Rehabilitation:** This includes 'medical and psychological care as well as legal and social services'.
- (d) **Satisfaction:** This should include, where applicable, such forms as: 'effective measures aimed at the cessation of continuing violations', 'verification of the facts and full and public disclosure of the truth', 'an official declaration or a judicial decision restoring the dignity, the reputation and the rights of the victim and of persons closely connected with the victim', 'public apology, including acknowledgement of the facts and acceptance of responsibility', 'judicial and administrative sanctions against persons liable for the violations', 'commemorations and tributes to the victims', and 'inclusion of an accurate account of the violations that occurred in international human rights law and international humanitarian law training and in educational material at all levels'.
- (e) **Guarantees of non-repetition:** These measures, which 'will also contribute to prevention', can include: reviewing and reforming laws contributing to or allowing gross violations of international human rights law and serious violations of international humanitarian law'.²⁶²

4.107 The international human rights pertaining to access to justice and redress emphasise the importance of equal access to remedies through the courts and justice systems, as well as access to redress beyond what is provided by law and through the courts. This emphasis is particularly significant in relation to sexual and reproductive violence that violates international human rights but is beyond the scope of court-based remedies such as violence that is lawful under domestic law or is of a historical nature.

Participation, Inclusion and Access to Resources and Supports

4.108 International human rights law also provides for rights directed towards enhancing

participation, inclusion and access to resources and supports that are relevant to positive sexual and reproductive experiences.

Health

4.109 Article 25 of the CRPD provides for the right to ‘the enjoyment of the highest attainable standard of health without discrimination on the basis of disability’, and States Parties must ‘take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive’.

4.110 The right to health is also found in other international human rights treaties. Article 12 of CEDAW specifically requires States Parties to ‘eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning’ and to also ‘ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period’. Article 12 of the ICESCR provides for the ‘right of everyone to the enjoyment of the highest attainable standard of physical and mental health’. Article 24 of CRC provides for the ‘right of the child to the enjoyment of the highest attainable standard of health’.

4.111 The former Special Rapporteur on Torture explains that the right to health cannot be used to justify torture or violence:

The right to an adequate standard of health care (“right to health”) determines the States’ obligations towards persons suffering from illness. In turn, the absolute and non-derogable nature of the right to protection from torture and ill-treatment establishes objective restrictions on certain therapies. In the context of health-related abuses, the focus on the prohibition of torture strengthens the call for accountability and strikes a proper balance between individual freedom and dignity and public health concerns. In that fashion, attention to the torture framework ensures that system inadequacies, lack of resources or services will not justify ill-treatment. Although resource constraints may justify only partial fulfilment of some aspects of the right to health, a State cannot justify its non-compliance with core obligations, such as the absolute prohibition of torture, under any circumstances.²⁶³

4.112 The UN CRPD Committee in its General Comment 3 (Women and Girls with Disabilities) has noted that women with disabilities face barriers in accessing health services, particularly those related to sexual and reproductive health:

Women with disabilities face barriers to accessing health and rehabilitation services; these include but are not limited to: lack of education and information on sexual and reproductive health and rights; physical barriers to gynaecological, obstetric and oncology services; and attitudinal barriers to fertility and hormone treatments. In addition, physical and psychological rehabilitation service provision, including counselling for acts of gender-based violence, may not be accessible, inclusive, age or gender sensitive.²⁶⁴

4.113 The UN CRPD Committee also observes ‘[a]ttitudinal barriers by health care staff and related personnel’ can ‘result in refusal of access of women with disabilities to healthcare practitioners and/or services, especially women with psychosocial or intellectual impairments, deaf and deafblind women, and women that are still institutionalized’.²⁶⁵

4.114 It also notes women with disabilities are ‘denied access to information and communication, including comprehensive sexuality education, based on harmful stereotypes which assume they are asexual and thus that they do not require such information. Information may also not be available in accessible formats’.²⁶⁶ This lack of access to sexuality information,

particularly for women with intellectual disabilities, deaf and deafblind women ‘can increase their risk of sexual violence’.²⁶⁷ The UN CRPD Committee also identifies issues with physical accessibility of ‘health facilities and equipment, including mammogram machines and gynaecological examination beds’, and the inaccessibility or unaffordability of safe transport for women with disabilities to attend healthcare facilities or screening programmes.²⁶⁸

- 4.115 The UN CRPD Committee in its General Comment 3 (Women and Girls with Disabilities) has noted the role of stereotypes in discrimination against mothers with disability:

*Harmful gender and/or disability stereotypes such as incapacity and inability, can lead to mothers with disabilities facing legal discrimination. As such, they are significantly overrepresented in child protection proceedings and disproportionately lose contact and custody of their children who are subject to adoption proceedings and/or can be placed in institutions. In addition, husbands can be granted separation and/or divorce on the basis of his wife’s psychosocial disability.*²⁶⁹

Living Independently and Being Included in the Community

- 4.116 Women and girls with disability are often at heightened risk of sexual and reproductive violence in closed, segregated and institutional settings and some forms of sexual and reproductive violence are a product of these settings. Article 19 of the CRPD recognises the equal right of people with disability to live in the community, to be fully included and to participate in community life, with choices equal to others. It means that people with disability have the same right as everyone else to exercise ‘freedom of choice and control over decisions affecting one’s life with the maximum level of self-determination and interdependence within society.’²⁷⁰

- 4.117 CRPD General Comment 5 (Living Independently and Being Included in the Community) makes clear that Article 19 is about autonomy and individual choice, liberty and security, freedom of movement and being a full participating member of the community on an equal basis with others. The UN CRPD Committee clarifies that any institutional form of support services which segregates and limits personal autonomy is not permitted by Article 19(b). Following deinstitutionalisation (i.e. closure of largescale institutions), groups homes and supported accommodation became an increasingly significant form of housing. The Royal Commission has acknowledged the closed and segregated nature of these alternative forms of housing. However, the UN CRPD Committee has explicitly stated that these forms of accommodation do not meet the right in Article 19:

*Neither large-scale institutions with more than a hundred residents nor smaller group homes with five to eight individuals, nor even individual homes can be called independent living arrangements if they have other defining elements of institutions or institutionalization. Although institutionalized settings can differ in size, name and set-up, there are certain defining elements, such as obligatory sharing of assistants with others and no or limited influence over whom one has to accept assistance from; isolation and segregation from independent life within the community; lack of control over day-to-day decisions; lack of choice over whom to live with; rigidity of routine irrespective of personal will and preferences; identical activities in the same place for a group of persons under a certain authority; a paternalistic approach in service provision; supervision of living arrangements; and usually also a disproportion in the number of persons with disabilities living in the same environment. Institutional settings may offer persons with disabilities a certain degree of choice and control; however, these choices are limited to specific areas of life and do not change the segregating character of institutions.*²⁷¹

- 4.118 The UN CRPD Committee identifies a clear link between institutional settings *per se* and

violence:

The cost of social exclusion is high as it perpetuates dependency and thus interference with individual freedoms. Social exclusion also engenders stigma, segregation and discrimination, which can lead to violence, exploitation and abuse in addition to negative stereotypes that feed into a cycle of marginalization of persons with disabilities.²⁷²

4.119 The UN CRPD Committee states that institutionalisation is inherently discriminatory:

Institutionalization is discriminatory as it demonstrates a failure to create support and services in the community for persons with disabilities, who are forced to relinquish their participation in community life to receive treatment. The institutionalization of persons with disabilities as a condition to receive public sector mental health services constitutes differential treatment on the basis of disability and, as such, is discriminatory.²⁷³

4.120 In its Thematic Study on the right of persons with disabilities to live independently and be included in the community, the United Nations High Commissioner of Human Rights similarly explains how institutionalisation *per se* creates the conditions for violence to flourish:

Cutting a person off from family, friends, education and employment through institutionalization results in social exclusion, creates barriers to inclusion in the community and reduces or denies the capacity of persons with disabilities to choose and plan their lives. That inhibits their autonomy by fostering dependency, preventing persons with disabilities from reaching their full potential in terms of independence and social participation. In addition, it has been widely documented that institutionalization may render persons vulnerable to violence and abuse, with women with disabilities particularly exposed to such risk. The risk of abuse is further exacerbated by the absence of public scrutiny, a lack of access to remedies, a fear of reporting violations, and disability-related communication barriers. Instances of abuse are in direct contradiction to the State's obligation to protect persons with disabilities from all forms of exploitation, violence and abuse, including their gender-based aspects (art. 16).²⁷⁴

4.121 The UN CRPD Committee explicitly and unequivocally states that Article 19 requires Governments to 'to phase out institutionalisation'²⁷⁵ through 'adopt[ing] clear and targeted strategies for deinstitutionalisation, with specific time frames and adequate budgets, in order to eliminate all forms of isolation, segregation and institutionalization of persons with disabilities.'²⁷⁶ States parties to the CRPD 'must adopt a strategy and a concrete plan of action for deinstitutionalization' and that deinstitutionalisation 'requires a systemic transformation'.²⁷⁷ The UN CRPD Committee's annotated outline of its Guidelines on Deinstitutionalization of Persons with Disabilities provides that States parties are charged to end institutionalisation and identify and address root causes of institutionalisation.²⁷⁸ The annotated outline provides that deinstitutionalisation processes should 'recognize and restore the dignity and the worth of persons with disabilities in society', '[f]oster accessibility and inclusion in the community', '[a]ddress trauma and provide redress to survivors of human rights violations in the context of institutionalization', and '[e]nsure accountability, end impunity, and bring to justice perpetrators of human rights violations in the context of institutionalization'.²⁷⁹ WWDA's Submission to the Royal Commission in response to its 'Group Homes Issues Paper' provides a detailed discussion and analysis of Article 19 and its integral importance to the implementation of all rights contained in the CRPD. WWDA's Submission clarifies that implementation of all of the elements of Article 19 is interdependent on implementation of other CRPD articles. This means that an examination of living arrangements for people with disability cannot be limited to

discussions of safe housing and support arrangements. WWDA's Submission re-iterates that Article 19 requires the end of segregation and isolation of people with disability from the community in institutional environments including group homes.²⁸⁰

- 4.122 The UN CRPD Committee has acknowledged that women and girls with disability are particularly disadvantaged in relation to institutionalisation:

*Often, women and girls with disabilities (art. 6) are more excluded and isolated and face more restrictions regarding their place of residence as well as their living arrangements owing to paternalistic stereotyping and patriarchal social patterns that discriminate against women in society. Women and girls with disabilities also experience gender-based, multiple and intersectional discrimination, greater risk of institutionalization and violence, including sexual violence, abuse and harassment. ... Therefore, when implementing the right to live independently and be included in the community, particular attention should be paid to gender equality, the elimination of gender-based discrimination and patriarchal social patterns.*²⁸¹

- 4.123 In CRPD General Comment 5 (Living Independently and Being Included in the Community), the UN CRPD Committee recognises the inherent risk to women and girls with disability in segregated settings:

*Since institutions tend to isolate those who reside within them from the rest of the community, institutionalised women and girls with disabilities are further susceptible to gender-based violence, including forced sterilization, sexual and physical abuse, emotional abuse and further isolation. They also face increased barriers to reporting such violence. It is imperative that States include these issues in their monitoring of institutions and ensure access to redress for women with disabilities who are exposed to gender-based violence in institutions.*²⁸²

- 4.124 The former UN Special Rapporteur on the Rights of Persons with Disabilities notes the greater use of institutionalisation in relation to older persons with disability, particularly at a time when 'younger persons with disabilities are increasingly encouraged and provided with support to live independently.'²⁸³ The former UN Special Rapporteur on the Rights of Persons with Disabilities sees the lack of support services in the community for older people with disability as a key driver of institutionalisation, including by reason of age limits on accessing disability supports.²⁸⁴ She states that institutionalisation should not be the solution to an absence of care in the community and that 'States need to transform their institutional forms of care for older persons with disabilities and to provide support and services within the community.'²⁸⁵

Respect for Privacy, the Home and Family

- 4.125 International human rights law provides rights related to privacy and protection of the home and family which are important to avoid discriminatory state interventions into sexuality and reproduction.
- 4.126 Article 22 of the CRPD provides that persons with disabilities should not be 'subjected to arbitrary or unlawful interference with his or her privacy, family, or correspondence or other types of communication' and that States Parties 'shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others'. Article 17 of the ICCPR also provides for the right to privacy.
- 4.127 People with disability also have the right to freedom of expression and opinion by reason of Article 21 of the CRPD, as well as pursuant to Article 19 of the ICCPR.

- 4.128 Article 23 of the CRPD provides for rights relating to non-discrimination in relation to relationships, marriage, parenting and family:

States Parties shall take effective and appropriate measures to eliminate discrimination against persons with disabilities in all matters relating to marriage, family, parenthood and relationships, on an equal basis with others, so as to ensure that:

(a) The right of all persons with disabilities who are of marriageable age to marry and to found a family on the basis of free and full consent of the intending spouses is recognized;

(b) The rights of persons with disabilities to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided;

(c) Persons with disabilities, including children, retain their fertility on an equal basis with others.

- 4.129 Article 16 of CEDAW provides that women should not be discriminated against in relation to marriage and family relations. Particular recognition is given to forced removal of Indigenous children as a form of genocide in Article 7 of DRIP, 'Indigenous peoples have the collective right to live in freedom, peace and security as distinct peoples and shall not be subjected to any act of genocide or any other act of violence, including forcibly removing children of the group to another group.'

- 4.130 In a more general vein, Article 23 of the ICCPR recognises the family as 'the natural and fundamental group unit of society and is entitled to protection by society and the State' and provides for the 'right of men and women of marriageable age to marry and to found a family'. Article 10 of ICESCR similar provides for protection and assistance of the family as the 'natural and fundamental group unit of society'.

- 4.131 In its General Comment 3 (Women and Girls with Disabilities), the UN CRPD Committee recognises the role of stereotypes about disability in limiting disabled women's right to found a family:

Wrongful stereotyping related to disability and gender are a form of discrimination, which particularly impacts the enjoyment of sexual and reproductive health and rights, and the right to a found a family. Harmful stereotypes of women with disabilities include but are not limited to beliefs that they are: asexual, incapable, irrational, lacking control and/or hypersexual. Like all women, women with disabilities have the right to choose the number and spacing of their children, as well as the right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.

... women with disabilities may face harmful eugenic stereotypes when it is assumed that women with disabilities give birth to children with disabilities and are thus discouraged or prevented from realizing their right to motherhood.²⁸⁶

- 4.132 The Report from the former Special Rapporteur on violence against women, its causes and consequences, (which focused specifically on the issue of violence against women with disabilities), stated that:

Women with disabilities are often treated as if they have no control, or should have no control, over their sexual and reproductive choices.....The forced sterilization of

women with disabilities remains a global problem. Women with disabilities who elect to have a child are often criticized for their decision and face barriers in accessing adequate health care and other services for themselves and their children. Although society's fear that women with disabilities will produce so-called "defective" children is for the most part groundless, such erroneous concerns have resulted in discrimination against women with disabilities from having children. There is a dichotomy between the notions, on the one hand, that motherhood is expected of all women and, on the other, that women with disabilities are often discouraged, if not forced, to reject motherhood roles, despite their personal desires. Research shows that no group has ever been as severely restricted, or negatively treated, in respect of their reproductive rights, as women with disabilities.²⁸⁷

Sexual and Reproductive Rights as a Key Human Rights Issue in Australia

- 4.133 United Nations human rights treaty bodies and special rapporteurs have identified sexual and reproductive rights as a key issue facing women and girls with disability in Australia.
- 4.134 Following her visit to Australia, the Special Rapporteur on Violence noted the following regarding its causes and consequences:

Compared to their peers, women with disabilities experience significantly higher levels of all forms of violence more intensely and frequently and are subjected to such violence by a greater number of perpetrators. Their experiences of violence last over a longer period of time and more severe injuries result from that violence. Beyond forms of violence such as sexual abuse, including rape and domestic violence, women and girls with disabilities are at particular risk of practices violating their sexual and reproductive rights, such as forced sterilization, forced abortion and forced contraception. On forced sterilization, the Special Rapporteur echoes concerns raised consistently by the United Nations human rights mechanisms, which have consistently recommended the adoption of legislation prohibiting sterilization in the absence of prior, fully informed and free consent, except where there is a serious threat to life or health.²⁸⁸

- 4.135 She also noted the failures of Australian legal and justice systems to prevent and redress violence:

The issue is not addressed adequately in legislation or policy frameworks on violence against women or women with disabilities, leading to an overall lack of accountability and impunity for perpetrators. There is no comprehensive and properly intersectional human rights policy framework to address all forms of violence against people with disabilities, especially women, and no legal, administrative or policy framework for the prevention, protection, investigation and prosecution of all forms of violence, exploitation, and abuse of people with disabilities.

Women and girls with disabilities face accrued difficulties in accessing remedies. The Special Rapporteur received details of cases where service providers had not reported some cases, or where the police had refused to investigate allegations of sexual violence because the alleged victims had a mental disability which they had decided would be problematic in terms of gathering evidence.²⁸⁹

Sterilisation and Other Restrictive Practices

- 4.136 Forced sterilisation²⁹⁰ of women and girls with disability, is an ongoing practice that remains legal and sanctioned by Australian Governments.²⁹¹ Forced sterilisation is recognised as a particularly egregious form of gender-based violence that has no place in a civilized world.²⁹² Since 2005, UN treaty bodies, the Human Rights Council, UN special procedures and international medical bodies have recommended Australia enact national legislation prohibiting forced sterilisation.²⁹³ The Human Rights Council made clear recommendations in this regard as an outcome of the Universal Periodic Review (UPR) of Australia in 2015.²⁹⁴ Forced sterilisation has been identified as an act of violence, a form of social control and a form of torture by the UN Special Rapporteur on Torture,²⁹⁵ and as a form of violence by the UN Committee on the Rights of the Child (CRC).²⁹⁶
- 4.137 Following its review of Australia in 2013, the UN CRPD Committee urged the Australian Government *‘to adopt uniform national legislation prohibiting the sterilization of boys and girls with disabilities, and adults with disabilities, in the absence of their prior, fully informed and free consent.’*²⁹⁷ In its subsequent 2019 review, the UN CRPD Committee expressed concern about forced and coerced sterilisation, abortion and contraception of women and girls with disability.²⁹⁸ It recommended the Australian Government review and amend laws to prohibit these practices.²⁹⁹ The CEDAW Committee has further clarified to Australia that: *‘decentralising government power through devolution or delegation does not negate the obligation on a State party to enact national legislation that is applicable throughout its jurisdiction.’*³⁰⁰
- 4.138 In relation to restrictive practices more broadly, following its periodic review of Australia in 2013, the UN CRPD Committee recommended the Australian Government *‘repeal all legislation that authorizes medical intervention without the free and informed consent of the persons with disabilities concerned, committal of individuals to detention in mental health facilities, or imposition of compulsory treatment, either in institutions or in the community, by means of Community Treatment Orders.’*³⁰¹ It also recommended ending incarceration in prison of unconvicted people with disability, particularly First Nations people with disability, and *‘review its laws that allow for the deprivation of liberty on the basis of disability, including psychosocial or intellectual disabilities, and repeal provisions that authorize involuntary internment linked to an apparent or diagnosed disability.’*³⁰² Also following its review of Australia in 2013, the UN CRPD Committee recommended the Australian Government take immediate steps to end the use of restrictive practices, including in schools, mental health facilities and hospitals and establish *‘an independent national preventive mechanism to monitor places of detention – such as mental health facilities, special schools, hospitals, disability justice centres and prisons.’*³⁰³
- 4.139 In its 2019 review, the UN CRPD Committee expressed serious concern about: *‘[I]nvestigation, policies and practices that permit the use of psychotropic medications, physical restraints and seclusion under the guise of “behaviour modification” and restrictive practices against persons with disabilities, including children, in any setting, including in justice, education, health, psychosocial and aged care facilities.’*³⁰⁴ It recommended the Australian Government:
- Establish a nationally consistent legislative and administrative framework for the protection of all persons with disabilities, including children, from the use of psychotropic medications, physical restraints and seclusion under the guise of “behaviour modification” and the elimination of restrictive practices, including corporal punishment, in all settings, including the home.’*³⁰⁵
- 4.140 The UN CRPD Committee also recommended the Australian Government ensure people with disability cannot be detained in solitary confinement. Also in its subsequent 2019

report on its second and third reviews of Australia, the UN CRPD Committee expressed concern about: '[l]egislative frameworks, policies and practices that result in the arbitrary and indefinite detention and forced treatment of persons with disabilities, and that such frameworks, policies and practices disproportionately affect Aboriginal and Torres Strait Islander persons with disabilities and persons with intellectual or psychosocial disabilities.'³⁰⁶ The Committee recommended the Australian Government '[r]epeal any law or policy and cease any practice or custom that enables the deprivation of liberty on the basis of impairment and that enables forced medical interventions on persons with disabilities, particularly Aboriginal and Torres Strait Islander persons with disabilities.'³⁰⁷

Supported Decision-Making

4.141 Australia continues to maintain that the CRPD '[a]llows for fully supported or substituted decision-making where necessary, as a last resort and subject to safeguards.'³⁰⁸ This is the basis of the Interpretative Declaration³⁰⁹ that Australia made at the time of ratification of the CRPD in 2008. This position has been maintained over the past 22 years, despite the fact that there has been consistent jurisprudence from the UN CRPD Committee that formal and informal substitute decision-making mechanisms are not compliant with the CRPD, and that these mechanisms must be replaced with fully supported decision-making mechanisms.³¹⁰

4.142 Following its reviews of Australia in 2013 and 2019, the UN CRPD Committee recommended the withdrawal of the interpretative declaration on Article 12 and the replacement of substitute decision-making with supported decision-making.³¹¹ During its 2019 review of Australia, the UN CRPD Committee noted it:

... regretted the continued denial of decision-making capacity to persons with disabilities, which... affected all other areas of life and led to the ongoing practices of forced institutionalisation..., involuntary medical treatments including forced sterilisation and surgery...'³¹²

4.143 As discussed in Section 2, in 2014 the ALRC provided its final report from its inquiry into barriers to equal recognition before the law and legal capacity for people with disability.³¹³ It made 55 recommendations for reform, with its key recommendation focused on the establishment of *National Decision-Making Principles and Guidelines* to guide reform of Commonwealth, State and Territory laws and legal frameworks. Following its 2019 review, the UN CRPD Committee recommended that Australia implement a 'nationally consistent supported decision-making framework', as highlighted by the ALRC. Eight years on from the ALRC Report, the Australian Government has still not provided its response to the Report or taken concrete steps to implement the UN CRPD Committee recommendation.

4.144 While it is recognised that Australia has an interpretive declaration in relation to Article 12, this does not prevent the Royal Commission from: (a) making recommendations that the Australian Government and State and Territory Governments abolish substituted decision-making and compulsory treatment laws on the understanding restrictive practices in general violate the right to legal capacity; and (b) recommending the Australian Government withdraw its interpretive declaration so that it assumes a formal obligation under the CRPD to take such action (though absence of such formal obligation does not prevent abolition of laws – there is much legislative reform that takes place in the absence of or irrespective of the existence of specific human rights obligations).

Redress

4.145 In its 2019 review, the UN CRPD Committee expressed concern about the 'lack of resources and redress mechanisms available to the Royal Commission into Violence,

Abuse, Neglect and Exploitation of Persons with Disabilities.³¹⁴ It recommended the Australian Government ‘[e]stablish a national accessible oversight, complaint and redress mechanism for persons with disabilities who have experienced violence, abuse, exploitation and neglect in all settings, including all those not eligible for the National Disability Insurance Scheme and, particularly, older women with disabilities’ and ‘[e]nsure adequate resources and a redress mechanism for the Royal Commission into Violence, Abuse, Neglect and Exploitation of Persons with Disabilities.’³¹⁵ This is consistent with the high level recommendation provided by the Senate Community Affairs References Committee, in its 2015 final report stemming from its Inquiry into Violence, Abuse and Neglect against People with Disability in Institutional and Residential Settings. The Committee recommended that:

- the Australian Government consider the establishment of a national system for reporting and investigating and eliminating violence, abuse and neglect of people with a disability, which should, at a minimum:
 - o be required to work in collaboration with existing state and territory oversight mechanisms;
 - o cover all disability workers, organisations and people with disability, without being restricted to NDIS participants;
 - o include a mandatory incident reporting scheme; and
 - o include a national worker registration scheme with pre-employment screening and an excluded worker register.
- These elements are best implemented through the establishment of a national, independent, statutory protection watchdog that has broad functions and powers to protect, investigate and enforce findings related to situations of violence, abuse and neglect of people with disability.³¹⁶

Segregation, Incarceration and Institutionalisation

4.146 Following its review of Australia in 2013, the UN CRPD Committee expressed concern at ‘reports of high rates of violence perpetrated against women and girls living in institutions and other segregated settings’ and recommended the Australian Government ‘investigate without delay the situations of violence, exploitation and abuse experienced by women and girls with disabilities in institutional settings, and that it take appropriate measures on the findings.’³¹⁷

4.147 On her mission to Australia, the Special Rapporteur on Violence has noted the high incidence of women with disability in the criminal justice system, including prison, and the lifelong sexual and physical violence they have experienced:

Criminalized women and girls have exceptionally high levels of mental and cognitive disability compared with the general population. They will have experienced very high rates of sexual and physical violence, most from their childhood or youth, and imprisonment and youth detention exacerbate their trauma.

Women with disabilities represent more than 50 per cent of the female prison population. More than half of all women incarcerated have a diagnosed psychosocial disability and a history of sexual victimization. The rate of incarceration of indigenous women with disabilities is higher than the equivalent figures for men. Indigenous women with disabilities are at risk of being detained, often without conviction, in

*prisons and forensic psychiatric units throughout Australia, enduring periods of indefinite detention, in some cases for years. Women with psychosocial disabilities and intellectual or learning disabilities are disproportionately classified as high-security prisoners and are more likely to be in high-security facilities than other prisoners.*³¹⁸

- 4.148 Following its periodic review of Australia in 2013, the UN CRPD Committee expressed concern *‘that despite the policy to close large residential centres, new initiatives replicate institutional living arrangements, and many persons with disabilities are still obliged to live in residential institutions in order to receive disability support.’* It thus encouraged the Australian Government to ‘develop and implement a national framework for the closure of residential institutions and to allocate the resources necessary for support services that would enable persons with disabilities to live in their communities’ and recommended it ‘take immediate action to ensure that persons with disabilities have a free choice as to where and with whom they want to live, and that they are eligible to receive the necessary support regardless of their place of residence.’³¹⁹ In its subsequent 2019 review, the UN CRPD Committee recommended the Australian Government: ‘[d]evelop a national framework aimed at closing all disability-specific residential institutions and preventing trans-institutionalization, including by addressing how persons with disabilities not eligible for the National Disability Insurance Scheme can be supported to transition from living in an institution to living independently in the community.’³²⁰
- 4.149 In 2020, Disabled People’s Organisations (DPOs), Disability Representative Organisations (DRO’s), and disability advocacy organisations from around Australia, developed and submitted a Paper to the Royal Commission entitled: *‘Segregation of People with Disability is Discrimination and Must End’*. This paper was endorsed by hundreds of disability organisations from around Australia, along with individuals, and organisations from across a wide range of sectors. The Paper highlights how CRPD provides the principles and standards to undertake the social transformation required to end segregation of all people with disability. It outlines four key principles to end all forms of segregation, and six priority and urgent actions required by Governments to end segregation of all people with disability.³²¹



5 PRINCIPLES AND CONCEPTS FOR UNDERSTANDING AND RESPONDING TO SEXUAL AND REPRODUCTIVE VIOLENCE

5. PRINCIPLES AND CONCEPTS FOR UNDERSTANDING AND RESPONDING TO SEXUAL AND REPRODUCTIVE VIOLENCE

- 5.1 In this section, we propose a principled and conceptual approach for exploring sexual and reproductive violence against women and girls with disability. In Section 6, we will apply aspects of this framework in the context of current experiences and laws impacting women and girls with disability in Australia.
- 5.2 We are proposing a principled and conceptual approach because the mere existence of the international human rights outlined in Section 4 is insufficient in itself to ensure realisation of sexual and reproductive rights and justice for women and girls with disability. As discussed in Section 2, sexual and reproductive violence against women and girls with disability is linked to deeply-embedded cultural understandings about disability, gender, sexuality, reproduction and violence that shape the scope of *what is known and who is authorised to express this knowledge* about sexual and reproductive violence against women and girls with disability. Thus, changing the way disability, gender, sexuality, reproduction and violence are understood is central to shifting how governments, justice systems, service systems and the broader community understand violence against women and girls with disability and in turn to realisation of their sexual and reproductive rights and justice.

Ableism

- 5.3 The status of people with disability is conventionally understood through a medical lens, or ‘medical model’, as an individual, natural deviation from ‘a biomedical norm.’³²² The medical model views disability as a ‘deficit’ within the individual, a deviation from bodily, cognitive and mental norms, which requires medical, rehabilitation, psychology and educational interventions to diagnose, treat or cure the individual.³²³ In this medical approach, people with disability are understood at a biomedical level as less than full humans, and as fundamentally different to people without disability. Disability is something undesirable and a burden on carers and society. Disability evokes (at best) pity and (at worst) disgust and contempt. Collective efforts should be directed towards curing and rehabilitating individuals so they can try to live something approximating a non-disabled life. As explained by Kafer:

*[D]isability is cast as a problematic characteristic inherent in particular bodies and minds. Solving the problem of disability, then, means correcting, normalizing, or eliminating the pathological individual, rendering a medical approach to disability the only appropriate approach. The future of disability is understood more in terms of medical research, individual treatments, and familial assistance than increased social supports or widespread social change.*³²⁴

- 5.4 When understood through a medical model, women with disability are considered naturally (in the dual sense of biomedically and self-evidently) incapable of participating in many sexual and reproductive experiences that ‘normal’, able humans enjoy such as intimate relationships, sexual pleasure, menstruation, reproduction, childbirth and parenting. To the extent that sexual and reproductive violence against women and girls with disability is recognised, it is within a paternalistic framing that affirms – rather than contests – their exclusion from sexuality and reproductivity.³²⁵
- 5.5 Yet this exclusion is viewed as an individualised phenomena rather than a structural and political phenomenon and thus does not register as injustice that demands accountability and redress and is the responsibility of governments and societies to remedy.

5.6 The first step in our principled and conceptual approach to sexual and reproductive violence against women and girls with disability is to challenge the conventional understanding of the status of people with disability. Kafer argues that taking a critical approach to disability involves attending to the questions of politicisation and depoliticisation. On the one hand, it involves asking how ‘the category of disability is used to justify the classification, supervision, segregation, and oppression of certain people, bodies, and practices’. On the other, a critical approach involves asking questions of depoliticisation, of how disability has been ‘depoliticized, removed from the realm of the political’, ‘which definitions and assumptions about disability facilitate this removal’, and what the effects are ‘of this removal’.³²⁶

5.7 ‘Ableism’ is one such critical approach towards disability which is advanced by some disability activists and critical disability scholars to understand the status of people with disability. When viewed through the lens of ableism, disability is not understood as it is through the medical model as an unfortunate condition residing in the individual and awaiting discovery through the expert and objective process of diagnosis. Instead, disability is understood as a negative attribute associated with abnormality, burden, unfitness and incapacity and when attributed to individuals and entire marginalised groups provides a justification for them to be devalued and dehumanised.

5.8 American abolitionist community lawyer, educator, and organiser, TL Lewis defines ableism as:

A system of assigning value to people’s bodies and minds based on societally constructed ideas of normalcy, productivity, desirability, intelligence, excellence, and fitness. These constructed ideas are deeply rooted in eugenics, anti-Blackness, misogyny, colonialism, imperialism, and capitalism. This systemic oppression that leads to people and society determining people’s value based on their culture, age, language, appearance, religion, birth or living place, “health/wellness”, and/or their ability to satisfactorily re/produce, “excel” and “behave.”³²⁷

5.9 Activist Kira Page explains, ableism ‘grants credibility and true humanity exclusively to able-bodied people and as such plays a central role in determining which individuals or communities are deemed the useless eaters, the dangerous, the unfit, or the disposable.’³²⁸

5.10 Writing about the concept of ‘ableism’, the former UN Special Rapporteur on the Rights of Persons with Disabilities has stated that:

The hegemony of ableism in society has perpetuated the idea that living with a disability is a life not worth living. There is a deep-rooted belief, carved with fear, stigma and ignorance, that persons with disabilities cannot enjoy a fulfilling life, that their lives are incomplete and unfortunate, and that they cannot attain a good quality of life. ... Notwithstanding all the progress achieved over recent decades concerning the rights of persons with disabilities, embracing disability as a positive aspect of humanity remains the final frontier to be conquered.³²⁹

5.11 When viewed through the lens of ableism, people with disability are relegated not simply to the status of socially undesirable in and of themselves, but as socially and economically burdensome on others and as having a depleting impact on the prosperity of their families, the wider population and the nation. In being unvaluable in the conventional sense of their labour, their bodies then become a source of extraction by other means or, failing this, become a target of elimination. This is explained by US Disability Justice activist Patty Berne:

Ableism tells us that some bodies are valuable and some are disposable. In the U.S. context, ableism has been forged with and through white supremacy, colonial

*conquest, capitalist domination, and heteropatriarchy so that bodies are valued for their ability to produce profit or have it extracted from them, or are otherwise excluded or eliminated through isolation, institutionalization, incarceration, and/or death.*³³⁰

- 5.12 The confinement and control of people with disability deemed disposable occurs across a variety of sites and systems, additional to the largescale disability institution and the prison which are typically associated with institutionalisation and incarceration. Critical disability scholars Chapman, Ben-Moshe and Carey have proposed the framework of the ‘institutional archipelago’, to refer to a network ‘made up of diverse services and spaces that all trace back to undifferentiated confinement and its ongoing reform - in which penalty is no more or less central than medical care or the right to education’.³³¹ Rossiter and Rinaldi offer the term ‘institutional violence’ to capture how violence is an inherent and defining feature of institutional environments:

*all practices of humiliation, degradation, neglect, and abuse inflicted upon institutional residents, regardless of intention or circumstance. ... while institutional violence is never acceptable, institutions themselves are inherently violent in form. We believe that practices of incarceration are in and of themselves violent, and necessarily produce further violence.*³³²

- 5.13 It is by reason of their impact on others that people with disability are undeserving of access to property, resources, and legal protections to survive and flourish.³³³ This undeservedness is apparent in government responses to the COVID-19 pandemic in Australia and other nations, where people with disability have been deprioritised for scarce medical resources, they have not had their deaths counted in COVID-19 death statistics, and their deaths from COVID-19 have been trivialised and rendered inevitable by reason of ‘underlying medical conditions’.³³⁴ It follows that autonomy is not simply a characteristic that certain individuals and groups possess naturally by reason of their inherent mental capacity. Rather, autonomy is an entitlement that is granted selectively to individuals and groups based on their economic and social deservedness, and thus the denial of autonomy to people with disability is an effect of their status as abnormal, unproductive, incapable and unfit which in turn renders their bodies legitimately violable.³³⁵ This selective granting of capacity is also seen in the context of other marginalised groups in contemporary and historical contexts such as First Nations peoples, women, transgender, feminine identifying, and non-binary people.³³⁶ Thus, through the lens of ableism, people with disability have bodies and lives that do not matter and whose experiences of violation, pain and death are not grievable because of their perceived uselessness and worthlessness to society and the nation.³³⁷ In turn, the lens of ableism illuminates how stigma, hatred, disgust and ambivalence towards people with disability is part of a larger project of maintaining ability, gender, sexuality, racial, class and other normative hierarchies that support able people’s enjoyment of advantage, inviolability and security and their status as full legal subjects, citizens and humans. This means that entitlement and access to property, resources and legal protection and recognition of the humanity of other individuals and groups in society is contingent on and benefits from the exposure of people with disability to disadvantage, violation and insecurity. The lens of ableism highlights both the harm done to people with disability through their abjected status, *and* the financial, political and social gains to others through their relatively higher status.

- 5.14 TL Lewis states that: ‘You do not have to be disabled to experience ableism.’³³⁸ Ableism is central to settler colonial (i.e. displacement, dispossession and elimination of Indigenous people) and racist privileging of white access to property, resources, and legal protections, and to neoliberalism which imposes responsibility on individuals for their own economic well-being and physical survival, while simultaneously maximising profit from the bodies of those least able to meet this ideal. This is because the concepts of abnormalcy, unproductivity, incapacity and unfitness which mediate the status and treatment of people with disability also mediate oppression of other marginalised individuals and groups such as those who are Indigenous, poor and racialised. Historically, this mediation might be

understood as a eugenics logics which groups together as biologically deficient and dangerous, a variety of marginalised groups such as people who are poor, racialised, Indigenous, have drug addictions, have STIs, are LGBTI, and who are sex workers.³³⁹ Specific historical examples include the White Australia policy which applied to racialised, non-white migrants and people with disability, and the ‘protectionist’ policies of the Stolen Generations era that justified removal of First Nations children on the basis of racist and colonial presumptions about the intellectual and mental incapacities of parents. Yet, the weaponisation of these concepts against other marginalised individuals and groups endure in a contemporary context, such as immigration policies that discriminate based on disability and Indigenous income management policies.³⁴⁰ Thus, ableism is part of a bigger picture of interlocking oppression, rather than being only about oppression of people with disability as an isolated sociological identity category somehow distinct to gender, class, race, and sexuality, and to structural conditions of settler colonialism and neoliberalism. The lens of ableism highlights how knowledge about and attitudes towards marginalised populations, which might be organised politically and intellectually as quite distinct from each other (e.g. disabled, racialised, poor), are interrelated through weaponisation of concepts of abnormalcy, unproductivity, incapacity and unfitnes.³⁴¹ Thus, ableism helps to understand the status of people with disability *and* other marginalised individuals and groups such as people who are poor, racialised, Indigenous, have drug addictions, have STIs, are LGBTI, and/or are sex workers. The relevance of ableism as a lens to understanding other contexts of oppression is demonstrated by the work of the movement #NoBodyisDisposable which draws on the concept of disposability as developed in the context of ableism to ‘connects the dots’ between social movements for people with disability, fat people, old people, people with HIV/AIDS or other illnesses and other marginalised groups to fight against common experiences of being determined disposable: ‘Once we are determined disposable, our bodies are directly injured and killed’.³⁴² It also follows that the lens of ableism also supports a more nuanced understanding of the oppression of people with disability as having differential impacts depending on an individual’s disability *and* their race, sexuality, gender, class and other identity markers and circumstances.

- 5.15 While violence against people with disability can be a profoundly personal act that causes harm to a specific individual and gain to a specific perpetrator, viewing disability through the lens of ableism has four implications that deepen our understanding of violence. One is that violence against people with disability takes place in a broader context of settler colonial and neoliberal nation-building. The second is that violence against people with disability and the lack of accountability and redress in the aftermath of such violence is justified on the basis of the social and economic burden they present to families, carers, guardians, the wider population and the nation. The third is the subjection of people with disability to violence arising from the denial of legal capacity and forced and coerced interventions that is related to their status as undeserving and burdensome. The fourth is that the preventing and responding to violence against people with disability must involve challenging the social and economic devaluation of people with disability in the broader context of settler colonial and neoliberal nation building and redistributing the resources and power that others gain through violence against people with disability.
- 5.16 Viewed through the lens of ableism, people with disability are positioned as less entitled to the resources and rights supporting sexuality and reproduction, such as rights to legal capacity, personal integrity, privacy and equality, and resources such as reproductive health services and financial, housing and other support. For example, in relation to reproduction, the possibility of people with disability having children can be seen as a drain on families and public services and a risk to their children. Beyond disentanglement to public goods, ableism is also about the disentanglement of people with disability to more intangible, private and personal phenomena that define full humanity, such as experiences of love, intimacy, and sexual pleasure, as well as affective states such as happiness, joy, desire, sadness and grief (noting it is common to disregard not only the genuineness of people

with disability's intimate relationships, but also the negative emotions that can follow the loss of a loved one). Mollow and McRuer observe the positioning of people with disability as illegitimate subjects and objects of pleasure and desire:

Rarely are disabled people regarded as either desiring subjects or objects of desire. And when sex and disability are linked in contemporary American cultures, the conjunction is most often the occasion for marginalization or marvelling: the sexuality of disabled people is typically depicted in terms of either tragic deficiency or freakish excess. Pity or fear, in other words, are the sensations most often associated with disabilities; more pleasurable sexual sensations are generally dissociated from disabled bodies and lives.³⁴³

- 5.17 People with disability are considered unentitled to experiences of love and intimacy, by reason of their incomplete citizenship and humanness.³⁴⁴ Indeed, Jones notes that it 'is no coincidence that a significant part of the dehumanisation of ableism is sexual ableism, where disabled people are stripped of agency and sexuality'.³⁴⁵ The disentanglement of people with disability to these intangible, private and personal phenomena is also apparent in relation to the permissible scope of feeling and sensation for people with intellectual disability in disability services:

Speaking about physical sensations may not be actively encouraged and this is nowhere more obvious than in the assumption that people with intellectual disability do not feel pain. Pain is not discussed and yet it is one of the main contributors to "challenging behaviours" by people who cannot vocalise what they are feeling. As an industry, the disability industry is committed to ensuring people are "behaving appropriately" both in their own homes and in public, and this amounts to social restraint. Expressions of pleasure by people who are pre- or non-verbal, for example, by making noises, may be discouraged and repressed by others, to ensure that they fit in with social norms. Natural expressions of joy, pleasure, grief, pain, and so on are limited to what is determined as socially appropriate, and thus people with intellectual disability are forced to fit their expressions to what is externally determined.³⁴⁶

- 5.18 Gill proposes that people with disability might be subjected to 'sexual ableism', which is '[a] system of imbuing sexuality with determinations of qualification to be sexual based on criteria of ability, intellect, morality, physicality, appearance . . .'.³⁴⁷ In particular, people with intellectual disability might be subjected to an 'extraordinary sexuality' that restricts and 'removes' those aspects of sexuality that are determined to be unachievable and inappropriate for people with an intellectual disability; including reproductive sex, self-authored sexual identity and often privacy and intimacy.³⁴⁸
- 5.19 Therefore, the lens of ableism deepens our understanding of sexual and reproductive violence in three respects. One is that, in being positioned as burdens, people with disability are denied the resources to support their sexuality and reproduction. The second is that sexual and reproductive autonomy and legal capacity is deliberately denied to people with disability for the benefit of others, thus exposing them to sexual and reproductive violence. The third is that people with disability are subject to the ontological violence of being socially, politically and legally denied the status of sexual and reproductive human subjects and deliberately excluded from full (or even any) sexual and reproductive enjoyment in order to reduce the perceived social and economic burden they (and their future children) impose on others and mitigate the impact of this burden on the overall strength and prosperity of the wider population and nation.
- 5.20 Therefore, in its work on sexual and reproductive violence, the Royal Commission should:
- approach the sexual and reproductive lived experiences of women and girls with disability as part of broader dynamics of ableism and the segregation,

inequality, exclusion and dehumanisation of people with disability;

- analyse how laws and practices related to sexual and reproductive violence are grounded in ableist understandings of disability, sexuality and reproduction, and
- analyse who benefits financially, socially and politically from sexual and reproductive violence against women and girls with disability.

Gendering Ableism

5.21 It is vital to *gender* ableism in the context of sexual and reproductive violence, specifically against women and girls with disability. By this we mean paying *specific* attention to the particular ways women and girls with disability are positioned as economic and social burdens, how women and girls with disability are disentitled access to embodied and social experiences that are gendered as female – such as menstruation, child birth and mothering, and gender-based violence – and the particular role of sexual and reproductive violence against women and girls with disability in settler colonial and neoliberal nation building.

5.22 Women with disability, disability activists and feminist disability legal scholars have observed the exclusion of women and girls with disability from full recognition as women. As WWDA has noted, women with disability ‘experience more extreme social categorisation than disabled men, being more likely to be seen either as hypersexual and uncontrollable, or de-sexualised and inert’ and ‘are more likely than disabled men to be portrayed in all forms of media as unattractive, asexual and outside the societal ascribed norms of “beauty”’.³⁴⁹ In a similar vein, Garland-Thomson states:

*Disabled women are, of course, a marked and excluded – albeit quite varied – group within the larger social class of women. The relative privileges of normative femininity are often denied to disabled women. Cultural stereotypes imagine disabled women as asexual, unfit to reproduce, overly dependent, unattractive – as generally removed from the sphere of true womanhood and feminine beauty.*³⁵⁰

5.23 Women and girls with disability are positioned as outside of gendered reproductive and sexual norms of behaviour and experience, as explained by Our Watch and Women with Disabilities Victoria:

*Women with disabilities may be viewed as failing to meet society’s expectations of how women should look or act, including the expectation that women should be mothers, carers and nurturers. This can contribute to beliefs about women with disabilities being incapable parents who should have their fertility controlled or their children removed, or being burdens on their carers, partners or lovers – stereotypes that are not applied to men with disabilities, who are often not expected to fulfil caring or nurturing roles. Further, stereotypes of women and girls with disabilities being vulnerable and in need of benevolent protection, or hypersexual and promiscuous, inform restrictive and controlling policies and practices over the sexual and reproductive health of women and girls with disabilities (for example, forced contraception or sterilisation). Particular stereotypes have also formed around particular impairment types, meaning some women and girls with disabilities will experience ableist stereotypes and forms of discrimination more acutely than others.*³⁵¹

5.24 Steele and Goldblatt explain the exclusion of women and girls with disability from gendered reproductive and sexual norms of behaviour and experience in the specific

context of menstruation:

Women and girls with disabilities are viewed as mentally and physically incapable of meeting gendered norms to conceal their menstruation and to control their sexuality and manage their fertility. Moreover, in being unable to meet gendered norms of motherhood and sexuality, women and girls with disabilities are viewed as burdens on those who provide care to them, with menstruation being seen as an additional and superfluous demand on labour and time for carers because women and girls with disabilities are viewed as not needing menstruation for reproductive reasons. As such, there are assumptions operating on at least three levels: (a) that women and girls with disabilities should conceal and control their menstruation; (b) that women and girls with disabilities are incapable of doing so; and (c) that it is inefficient and unnecessary for others to support women and girls with disabilities to menstruate.³⁵²

- 5.25 Gendered ableism is apparent in eugenics logics which place particular emphasis on the role of female sexuality and reproduction in the genetic transference of un/fitness between generations. This was exemplified by the US Supreme Court decision of *Buck v Bell*,³⁵³ which justified the sterilisation of a young disabled woman Carrie Buck on the basis that this would stop future generations of ‘imbeciles’:

We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the State for these lesser sacrifices, often not felt to be such by those concerned, to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind.

- 5.26 *Buck v Bell* ‘expresses the idea that the existence of disabled people impedes or otherwise harms everyone else’³⁵⁴ and that the sexual and reproductive activity of women with disability is a specific threat to the prosperity (‘sap the strength’) of the wider population and nation. Yet, as offensive as this passage might read to a contemporary audience, such sentiments do not only constitute historical injustices. Disability activists and critical disability scholars observe that these kinds of logics still carry on in approaches to sexuality and reproduction of women and girls with disability in our current era and, as we discuss in Section 5, are reflected in court judgments and legislation. These eugenics logics pervade all forms of sexual and reproductive violence, particularly those preventing women and girls’ reproduction and parenting such as sterilisation of women and girls with disability, menstrual suppression of women and girls in disability service settings, and state removal of children from parents with disability.³⁵⁵
- 5.27 On a related note, gendering ableism must be done in the specific social, economic, legal and historical contexts of Australian nation-building, shaped as they are by the ongoing impacts of eugenics, settler colonialism and, more recently, neoliberalism. In particular, attention must be paid to the relationship between sexual and reproductive violence against women and girls with disability and the role of women’s bodies and specifically their sexuality and reproduction in Australian nation-building.³⁵⁶ For example, as we discuss in Section 5, forced sterilisation of women and girls with disability and forced removal of their children is often driven by concerns about the genetic transference of disability and the economic and social impacts of their disability on their family and paid carers.
- 5.28 It is important not to assume all women and girls with disability are equally subjected to oppression at the intersections of disability and gender. Erevelles, for example, argues for the necessity of attention to the ‘actual historical, social, and economic conditions that influence (disabled) people’s lives, conditions further mediated by race, ethnic, gender, class and sexual politics.’³⁵⁷ Not all women and girls with disability are equally exposed and

subjected to gendered ableist violence. Some women and girls with disability who are also poor, Indigenous, LGBTI, or racialised might be more targeted for sexual and reproductive violence. This is because, as discussed earlier in this section, the weaponisation of ableist notions of abnormalcy, unproductivity, incapacity and unfitness against various marginalised individuals and groups (discussed earlier in this section) hierarchise people along lines of disability and gender, and other aspects of identity such as race, sexuality, and class. Thus, contextualising gendered ableism in intersectionality (other dynamics of identity and diverse social circumstances) and interlocking dynamics of oppression (notably settler colonialism, neoliberalism, racism and heterosexism) facilitates closer attention to different experiences of sexual and reproductive violence between women with disability.

- 5.29 Intersectionality is useful in exploring how disability, gender and other dimensions of identity ‘intersect in shaping structural, political, and representational aspects of violence’ against women and girls with disability.³⁵⁸ As Collins and Bilge explain: ‘[a]s an analytic tool, intersectionality views categories of race, class, gender, sexuality, class, nation, ability, ethnicity, and age – among others – as interrelated and mutually shaping one another’ and ‘while often invisible, these intersecting power relations affect all aspects of the social world.’³⁵⁹ Intersectionality involves nuanced analysis of power relations ‘both via specific intersections – for example, of racism and sexism, or capitalism and heterosexism – as well as across domains of power – namely, structural, disciplinary, cultural, and interpersonal’³⁶⁰ and directs attention to ‘the importance of examining intersecting power relations in a social context’, such as settler colonialism.³⁶¹ A further aspect is relationality, which ‘embraces a both/and analytical framework that shifts focus from seeing categories as oppositional, for example, the differences between race and gender, to examining their interconnections.’³⁶²
- 5.30 It is vital to consider how the differing material, economic and social conditions of women and girls with disability (in a contemporary and historical context) inform their unequal exposure to sexual and reproductive violence. We must also be attentive to other dynamics of identity such as race, class and Indigeneity and diverse aspects of social circumstances, such as past or current experiences of institutionalisation, child welfare, victimisation (including state violence), homelessness, drug use and criminalisation. Some women and girls with disability might more easily fit normative ideals of the responsible disabled subject who is trying to ‘overcome’ their disability and contribute to society (or at least is viewed as not using too many public resources) and thus is more closely approximating ideals of normalcy and productivity. In contrast, others who do not fit these normative ideals (e.g., because they are poor, are using drugs, have been in prison, live in a boarding house) are seen as having ‘transgressive’ or ‘non-normative’ forms of disability³⁶³ ‘that do not fit into the neat packages of a highly mobile, young, wheelchair user working to be independently productive, are easily dismissed as not truly deserving of benefits or accommodations.’³⁶⁴ This latter group might be more exposed to sexual and reproductive violence because their health and wellbeing, social and economic participation, enjoyment of rights and ultimately their bodies and lives are more of a burden on others and more of a threat to the prosperity of the nation.
- 5.31 Sexual and reproductive violence does not happen in a vacuum where women and girls with disability are otherwise living empowering and equal lives. Rather, these violations are one part of broader individual and structural circumstances of gendered ableist violence and segregation, discrimination and inequality they experience across their life and life courses. For many women and girls with disability, particular incidents of sexual and reproductive violence are not isolated phenomenon in a life otherwise free of violence. Rather, incidents of sexual and reproductive violence are generally one dimension of violence in lives that are more broadly characterised by poverty, violence, segregation and social, economic and political exclusion which is often facilitated by legal and service systems. Incidents of sexual and reproductive violence have lasting impacts and continue

to shape the lives of women and girls with disability, including by reason of the ongoing psychological impacts of sexual and reproductive violence, the long-term nature of legal orders such as guardianship or mental health orders that enable incidents of sexual and reproductive violence, the permanent or long-term nature of sexual and reproductive medical treatments, the lasting grief and trauma associated with removal of children, and physical alterations to women and girls' bodies which permanently prevent them from accessing sexual and reproductive experiences. Thus, through the lens of gendered ableism we can expand the temporal and structural scale of analysis in order to understand how sexual and reproductive violence contributes to a mode of existence that denies women and girls with disability opportunities to flourish (or even live). In this respect, we can draw on Berlant's concept of 'slow death', which is defined as 'the physical wearing out of a population and the deterioration of people in that population that is very nearly a defining condition of their experience and historical existence.'³⁶⁵ Drawing on the concept of slow death, we can consider how sexual and reproductive violence contributes to precarity and premature death across the lives of women and girls with disability.

5.32 Therefore, in its work on sexual and reproductive violence, the Royal Commission should:

- pay focused attention to how gendered ableist assumptions about women and girls with disability as excluded from normative understandings of femininity, sexuality and reproduction enable violence against women and girls with disability and justify a lack of accountability and redress in the aftermath of such violence,
- analyse how laws and practices related to sexual and reproductive violence are grounded in gendered ableism,
- analyse how lived experiences of sexual and reproductive violence are shaped by interlocking dynamics and forces of oppression, including settler colonialism, racism and heteropatriarchy
- be attentive to the longer term harms and injustices of sexual and reproductive violence, including the impact of harms across generations, and
- interrogate similarities and continuities between historical sexual and reproductive injustices associated with settler colonialism and eugenics and contemporary sexual and reproductive violence against women and girls with disability.

Disability, Settler Colonialism and Gendered Ableism

5.33 In order to support a critical analysis of gendered ableism that is grounded in place, it is important to specifically consider the role of settler colonialism in the experiences of First Nations women and girls with disability, and to connect sexual and reproductive violence to ongoing dispossession and displacement, rooted in the denial of First Nations peoples self-determination and sovereignty.

5.34 First Nations people with disability have always identified the heightened marginalisation and violence they experience. For example, the late Uncle Lester Bostock OAM, a Bundjalung man and leader of the First Nations disability movement, proposed the concept of 'double disadvantage'³⁶⁶ to explain the experiences of First Nations people with disability as experiencing racial and disability discrimination.

5.35 Scott Avery, a Worimi man who is profoundly deaf, builds on Bostock's work in his research with First Nations people with disability. Avery illuminates the significance of intersectional

discrimination experienced by First Nations people with disability:

In addition to racism and ableism as discrete forms of discrimination, the research detected a third experience – ‘intersectional discrimination’ – which is a unique interaction of race and disability-related discrimination experienced by people who are both Aboriginal and/or Torres Strait Islander and have disability. An example from the testimony is an account of an Aboriginal man with cognitive impairment who is harassed at a shopping centre by security guards who assume he is drunk. In this example, the physical presentation of a person with cognitive impairment interacts with populist prejudices about Aboriginal people and drinking which exposes a person who is Aboriginal and has cognitive impairment to a heightened vulnerability not adequately explained by racism or ableism alone.³⁶⁷

- 5.36 Avery proposes a ‘matriculation pathway’ is experienced by First Nations people with disability due to the compounding impacts of intersectional discrimination across one’s life:

Intersectional discrimination is not a point-in-time concept. The detrimental consequences of intersectional discrimination at one point in life can be lifelong, as it increases the likelihood of being exposed to future experiences of exclusion and discrimination. ... inequality experienced by Aboriginal and Torres Strait Islander people with disability accumulates over the course of their lives. Even before they are born, the social circumstances into which Aboriginal and Torres Strait Islander people are born can add to the burden of disability. The impact of undetected and unsupported disability in their early childhood carries forward into the schooling years. This compounds into greater inequalities in later life, effectively placing them on a ‘matriculation pathway into prison’, as opposed to further education and employment.³⁶⁸

- 5.37 Avery proposes that an understanding of the matriculation pathway then provides opportunities ‘to identify the pivot points which can alter the life trajectory by providing timely supports to their disability.’³⁶⁹

- 5.38 Bostock explained how First Nations people become disabled through settler colonialism:

Aborigines have experienced a long history of their children being taken away from them and placed into institutions where over the generations, they have become the most institutionalised group, of people in Australian society. This institutionalisation and the policies of cultural decimation have led to generations of physical, mental and intellectual disabilities.³⁷⁰

- 5.39 Similarly, Avery explains the ongoing, disabling impacts of colonisation:

The process of colonisation has had multiple and continuing impacts on the Aboriginal and Torres Strait Islander population. First, massacres and the introduction of foreign diseases drastically reduced the Aboriginal population in the first decade following European contact. Second, the imposition of guns, alcohol, tobacco and sugar as agents of colonisation resulted in hugely increased levels of disablement among the surviving population and their future generations, which has had a long-term impact on population health status. Third, the colonisation itself was founded on the imperial legal doctrine of ‘terra nullius’, literally meaning ‘nobody’s land’. To morally justify the dispossession of the native inhabitants from their land, Aboriginal and Torres Strait Islander people were treated as subhuman and viewed as inferior by their European conquerors. The humanity of Aboriginal and Torres Strait Islander people was effectively denied, and the impact of racial discrimination affecting the rights, inclusion and social structure of Aboriginal and Torres Strait Islander people is still evident in Australia today.

Colonisation had a particular impact upon Aboriginal and Torres Strait Islander people with disability, centring them at a convergence of armed aggression dispossessing them from their land as Aboriginal people, alongside their social ‘othering’ as people with disability. Colonisation commenced in a period in history known as the Enlightenment, an intellectual and political movement which emerged in Europe in the late 18th and early 19th century, characterised by scientific thought, reasoning, and the promotion of personal liberty. An influential thinker in Britain at the time was Scottish economist Adam Smith, whose book the Wealth of Nations included a theory of market economics. Amongst the key ideas of the theory of market economics is a concept of ‘human capital’, which equates people to physical resources in a production process. A corollary of ‘human capital’ is the notion of a ‘disabled person’, an idea that was socially constructed to categorise those people that were perceived to be unable to participate in the market economy, or raw materials in a production process and discarded as not meeting a standard specification. These were the emergent ideas at the time and became the foundation for the social and political economy of the new colony. Hence, the native population of Australia faced cultural upheaval on multiple fronts. Over and above the violent aggression of colonisation was the establishment of a social order completely at odds with their cultural values of diversity and inclusion.

Some Aboriginal people, already subjugated by armed force and the pejorative influences of the early colonial press, also acquired a new label of ‘disability’, adding another dimension to their dehumanisation, further marginalising them even amongst their own people. In the two and a half centuries since, Aboriginal and Torres Strait Islander people with disability have been vulnerable to the worst of the worst in the social engineering that has taken place post-colonisation: whether it is the over-incarceration of Aboriginal and Torres Strait people; the institutionalisation of people with disability in mental asylums and institutions, and the structural violence that occurred within them; the removal of children from their families during the Stolen Generations and beyond; or exclusion from equal participation in a market economy. In appreciating how enshrined the forces of their exclusion have become, the current status of Aboriginal and Torres Strait Islander people with disability is a reminder that the echoes from a distant past still resonate loudly today.³⁷¹

- 5.40 Disability diagnosis and disability-specific forced and coercive interventions can facilitate and mask as natural, apolitical and noncolonial enslavement, dispossession, child removal, disenfranchisement, incarceration, sterilisation and genocide of First Nations people and other racialised minorities.³⁷² Labelling First Nations people as disabled can be used to justify the logic of elimination and settler colonial violence.³⁷³ Writing in the context of government policy on First Nations health, Watego argues that the association between sickness, deviance and death and First Nations people is central to settler colonial rule:

The settlers have long insisted that our death was destined, that our race was doomed, and that we, as a people, were vanishing. Our disappearance was inevitable because it was necessary to sustain terra nullius, the foundational myth of Australia. Black deaths rationalised White invasion and land expansion in Australia.

In a little over 100 years of White presence, they did not feel it was necessary to include us in their Constitution. Having been so successful in their work, they were anticipating our imminent departure – not to another land, but rather to be buried in our own lands.

In our dying, rather than in our living, our bodies mattered most to the colonial project.³⁷⁴

- 5.41 In a similar vein, Wiradjuri woman Vanamali Hermans writes of her reflections on hospitals

and settler colonialism in light of her experiences with her mother's hospitalisation:

As hospitals and aged care living centres become the frontlines in the struggle against COVID-19, now more than ever we must confront and interrogate the role these institutions play in our lives, and how we must reshape them towards the social good we need in our communities.

I am confronted by both the immensity and urgency of this task as someone who has spent the better half of my young adulthood in these spaces, caring for sick and disabled family. My mum Julie, a Wiradjuri woman, spent the last years of her life institutionalised in hospitals, subjected to increasing violence and having her identity weaponised against her. Having witnessed the way these places controlled and ultimately ended my mum's life, I have come to understand the way in which hospitals and health professionals alike are required to perform to a strict set of politics that dispose of disabled people, Blackfullas, other Black and Brown communities, poor people and those considered not 'human enough'.

My personal experiences have reflected a narrative oppressed people the world over understand to be true: hospitals do not exist in a social vacuum. Hospitals are not inherently benevolent, nor are we promised healing and safety inside of them. They are institutions like any other that grasp tightly to capitalist ideas about which bodies may be productive and therefore considered 'worthy' of continued life. They are institutions that grasp tightly to eugenicist and colonial politics that would see many of us killed off, and they are institutions that stratify and limit access to care depending on capitalist paradigms of access and affordability. Poverty is exacerbated by insufficient or inappropriate health resources, and further reinforced by continuing austerity measures. Chronic underfunding of hospitals makes it impossible to ensure the type of care that would see safety and healing for our communities, to break cycles of distrust.³⁷⁵

- 5.42 Chelsea Watego (formerly Bond) who is a Munanjahli and South Sea Islander woman argues that the oppression of First Nations people needs to be understood as inextricably connected to Country and self-determination:

The settlers have long insisted that our death was destined, that our race was doomed, and that we, as a people, were vanishing. Our disappearance was inevitable because it was necessary to sustain terra nullius, the foundational myth of Australia. Black deaths rationalised White invasion and land expansion in Australia. ...

...

Blackfullas are not seeking a revitalised citizenship that recognises our dignity and humanity – we are insisting upon our sovereignty as First Nations peoples.

We refuse to talk about our lives independently of our land. We remind them every day that we are still here in this place – and it is their presence on our lands that poses the real problem, not our lives.³⁷⁶

- 5.43 In the specific context of health policy, Watego et al argue for a series of transformations towards centering First Nations self-determination and justice for racism. These include:

A foregrounding of Indigenous sovereignty rendering visible the strength, capability and humanity of Aboriginal and Torres Strait Islander peoples, services and communities in all processes of health policy formation and implementation, not as partners but as architects. ...

The establishment of awareness-raising campaigns that make clear the various

*ways in which Aboriginal and Torres Strait Islander peoples may seek justice when experiencing discrimination within the health system, and commensurable resourcing of legal services to support Indigenous peoples to take action.*³⁷⁷

- 5.44 Avery argues for a strength-based approach to disability in relation to First Nations people with disability, which acknowledges the culture of inclusion towards people with disability in First Nations cultures that ‘seeks to improve the human condition through positive affirmation, as distinct to merely negating the adverse impact of difference’ as is apparent in conventional Western medical approaches to disability.³⁷⁸
- 5.45 Thus, First Nations approaches to disability, health and settler colonialism illuminate how sexual and reproductive violence can itself disable First Nations women and girls with disability – physically, psychosocially and/or cognitively – and is connected to the ongoing dispossession and displacement of First Nations people and denial of their self-determination and sovereignty. Moreover, First Nations approaches to disability, health and settler colonialism also help to understand how diagnoses of disability and notions of abnormalcy, unproductivity, incapacity and unfitness specifically associated with disability have been used to justify *and mask* as natural, apolitical and noncolonial sexual and reproductive violence against First Nations women with disability, such as sterilisation, forced removal of their children, and the lack of justice system responses.³⁷⁹ Moreover, recalling that ableism is associated with nation building, sexual and reproductive violence against First Nations women and girls with disability is about violation, marginalisation, dehumanisation and harm to individual women and girls, as much as it is about white abled settler nation building for the benefit of colonising forces.³⁸⁰ Last, First Nations approaches to disability, health and settler colonialism assist in understanding the relationship between preventing and responding to sexual and reproductive violence against people with disability and supporting First Nations self-determination and sovereignty.
- 5.46 Therefore, in its work on sexual and reproductive violence, the Royal Commission should:
- analyse the relationships between settler colonialism, ableism and sexual and reproductive violence against First Nations women and girls with disability
 - explore how sexual and reproductive violence against First Nations women and girls with disability sustains dispossession, displacement and genocide of First Nations people
 - interrogate the connections between sexual and reproductive violence and policing and incarceration of First Nations women and girls with disability, and
 - explore the critical role First Nations self-determination and sovereignty plays in preventing and responding to sexual and reproductive violence against First Nations women and girls with disability.



Dehumanisation of Women and Girls with Disability: Ontological and Epistemic Violence

- 5.47 Understanding sexual and reproductive violence against women and girls with disability through the lens of gendered ableism can be further nuanced by considering epistemic and ontological violence. By this we mean the ways that women and girls with disability are denied the authority to define their sexual and reproductive preferences, needs and experiences (epistemic violence) and to be recognised as having a legitimate way of being and existing in world (ontological violence).
- 5.48 Ontological violence relates to how disability, as a way of being in the world, renders individuals with disability as deserving of violence and incomprehensible as grievable victims. Ontological violence is a key dynamic of sexual and reproductive violence when viewed through the lens of ableism, because ableism is about the lack of entitlement that people with disability have to access to property, resources, and legal protections to survive and flourish and ultimately to exist.
- 5.49 Kafer proposes an ontology of disability grounded in temporal relations between disability and futurity. Conventionally, the envisioning of a desirable future is one without disability and the negation of the legitimate existence of disabled people.³⁸¹ This is most evident in medical initiatives such as genetic testing for disability, utilising assisted reproductive technologies to avoid disabled babies, and a focus on developing medical cures for disability. It is also reflected in education, recreational and employment initiatives that make social, economic and political inclusion of people with disability conditional on their approximation of normative expectations of behaviour and appearance. Viewed through an ableism lens, negative ontologies of disability are inextricably connected to violence through being bound up with carcerality (i.e. the necessity of incarcerating and controlling people with disability), disposability (i.e., people with disability as burdensome and unvaluable) and violability (i.e., the legitimacy of intervening in the bodies and lives of people with disability).³⁸² The illegitimacy of people with disability's ways of being in the world *as disabled* positions them as less than full humans now and in the future, contributing to an understanding of violence as necessary to expel disability from humanity.³⁸³ Their dehumanisation then provides a basis on which they can be violated with impunity, a point that has also been made in relation to other marginalised groups such as racialised people³⁸⁴ and First Nations and Indigenous peoples.³⁸⁵ In turn, people with disability are not 'grievable' in their injury or deaths – as less than humans, their suffering and death is not recognised as a social loss.³⁸⁶
- 5.50 While violence against people with disability is often presented as driven by humane and benign intentions, *underpinning* these intentions are particular assumptions about negative ontologies of disability.³⁸⁷ Thus, while the *prima facie* intention behind some coercive interventions might be presented as 'harmless', this is only comprehensible as harmless in a cultural context that devalues and dehumanises people with disability. This cultural context is informed by the benevolent and paternalistic narratives inherent to settler colonialism and the (alleged) beneficence of the welfare state.³⁸⁸
- 5.51 Ontological violence is gendered. What counts for recognition as a legitimate existence is not only about normative understandings of what it means to be a normal, productive, intelligent and fit human and but also normative understandings of what it means to be a normal, productive, intelligent and fit female.³⁸⁹ People with disability are subject to ontological violence of not being understood as sexual beings:

How do people with disabilities conceptualise, experience and engage with

themselves as sexual beings? In addition to the specific constraints imposed by a particular disability, such experiences crystallise within the broad rubrics of culture, socialisation, socio-economic class, gender, caste and other specific locations that contribute to particular configurations of gendered sexual identities at the individual level. Poverty, stigma, discrimination and a host of other external factors shape personal experiences of shame, sexual desire and desirability or lack thereof, sexual confidence and esteem. In most cultures, the pleasure associated with sexual intimacy is both decried and denied. Additionally, apart from legally defined acts like rape and molestation, the violence associated with both normative sexual life and the absence of any acknowledged sexual relationship are strategically enveloped in a veil of silence. While sexual violence towards people with disabilities is moderately well documented, and human rights violations in this regard are well recognised, crucial analysis of personal context and gender/sexual dynamics, are limited.³⁹⁰

5.52 Moreover, sexual and reproductive violence against women and girls with disability can be understood as ontological violence because it denies to them many of the embodied and social experiences that characterise what it means to be a human – intimate and loving relationships, articulating thoughts and wishes about sexuality, reproduction and parenting, experiencing sexual pleasure, and experiencing the relationship between parent and child. Sexual and reproductive violence actually serves to deny to women and girls with disability access to specific experiences marked as normative for females, such as menstruation, reproduction, childbirth and mothering.³⁹¹ Furthermore, the lack of comprehensive data collection on sexual and reproductive violence also invisibilises this violence and itself sends the message that individuals who experience these forms of violence do not count as victims: ‘We count what matters, and what matters counts’.³⁹²

5.53 ‘Epistemic violence’ is a further and closely related dynamic of violence. Epistemic violence can be understood by reference to Miranda Fricker’s work on ‘epistemic injustice.’ Fricker explains epistemic injustice as ‘a wrong done to someone specifically in their capacity as a knower.’³⁹³ She identifies two specific forms of epistemic injustice: testimonial injustice and hermeneutical injustice. She explains:

Testimonial injustice occurs when prejudice causes a hearer to give a deflated level of credibility to a speaker’s word; hermeneutical injustice occurs at a prior stage, when a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences. An example of the first might be that the police do not believe you because you are black; an example of the second might be that you suffer sexual harassment in a culture that still lacks that critical concept. We might say that testimonial injustice is caused by prejudice in the economy of credibility; and that hermeneutical injustice is caused by structural prejudice in the economy.³⁹⁴

5.54 In a similar vein, Jill Stauffer offers the term ‘ethical loneliness’ to refer to a situation where marginalised people are subject to profound harm, and then do not have that harm recognised by government and broader society as injustice.³⁹⁵

5.55 Epistemic violence in relation to people with disability is apparent in: the overriding of their consent and the failure to recognise their capacity to make their own decisions and choices; the pathologising of their expression, resistance and distress; and the absence of social, political and legal paradigms to recognise the full spectrum of their experiences of injustice and violence.³⁹⁶ Epistemic violence arises from assumptions that people with disability (particularly those with intellectual disability, psychosocial disability, communication disability or hearing disability) do not have the mental capacity to articulate their views and needs and thus to give or withhold consent. For women and girls with disability, these assumptions are compounded by assumptions about women as less capable than men to think rationally and independently.

5.56 Epistemic violence is also facilitated through health disciplinary knowledge and practices which renders individuals legible and knowable by reference to diagnostic frameworks of disability. As Chapman and Withers note: '[c]asting a person or an imagined type of person as thoroughly knowable is always violent. It involves subtracting purpose, responsibility, agency, or animacy from framings of how that person or "those people" function.'³⁹⁷ It is also facilitated by legal concepts such as 'capacity', as well as substituted decision-making laws and legal processes that prevent individuals from having their choices and views legally recognised. It is apparent in the actions of disability service providers in denying people with disability choices in even the smallest and perhaps seemingly mundane aspects of their lives, such as eating, sleeping patterns, and social interactions.³⁹⁸

5.57 Engaging with the epistemic violence associated with sexual and reproductive violence not only illuminates additional harms to women and girls with disability, but also the productive and positive impact on others by validating and empowering the expertise, intellect and authority of legal, medical and social care professionals and disability service providers.³⁹⁹ Beyond this, epistemic violence reinforces broader liberal constructions of legal capacity that have historically disadvantaged women and girls with disability and numerous other marginalised populations (e.g. First Nations peoples, poor people, women) and narrowed access to property, resources and political participation to a minority of privileged people.⁴⁰⁰ Framing women and girls with disability as lacking capacity positions them as helpless, vulnerable and at risk of exploitation at the same time that it positions the justice system and the state as benevolent rescuer and thus non-violent.

5.58 Frohmader explains how epistemic and ontological violence are interrelated in relation sexual and reproductive violence against women and girls with disability:

denial of these rights and freedoms is predicated on the assumption - usually implicit - that there are degrees of being human, and that only the "fully human" are entitled to enjoy the advantages of our society and the full protection of its laws. Since ability and intelligence are highly valued in our society, they are closely associated with being human. 'diminished ability and intelligence', on the other hand, is equated with lower forms of life. Women with disabilities have typically been perceived as sub-human - lacking such basic human needs as the need for love, intimacy, identity and freedom. dehumanising conditions - such as those which still pervade many of our state institutions - have been rationalised on the basis that women with disabilities do not have the same needs and feelings as the "fully human", and hence that they do not need privacy, personal property, recognition, intimacy or freedom of choice. Viewed as "undesirable" and as potential threats to society, women with disabilities have often been isolated in institutions and otherwise prevented from fully participating in society.⁴⁰¹

5.59 Therefore, in its work on sexual and reproductive violence, the Royal Commission should:

- centre the lived experiences and narratives of women and girls with disability
- analyse the central role of epistemic injustice in sexual and reproductive violence
- explore the negative ontologies of disability – such as disposability, carcerality, and violability – that underpin sexual and reproductive violence against women and girls with disability
- analyse how ontological and epistemic violence enable sexual and reproductive violence against women and girls with disability and justify a lack of accountability and redress in the aftermath of such violence, and

- explore how sexual and reproductive violence contributes to exclusion of women and girls with disability from social, political and legal subjectivity and citizenship, and to their further dehumanisation.

Economies of Sexual and Reproductive Violence

- 5.60 Utilising the lens of ableism involves situating sexual and reproductive violence against women and girls with disability in the context of neoliberalism through which society imposes responsibility on individuals for their own economic well-being and physical survival, while simultaneously maximising profit from the bodies of those least able to meet this ideal. As such, ableism illuminates the political economy of sexual and reproductive violence, and the financial gain through harm and injustice to women and girls with disability.
- 5.61 Women and girls with disability are often excluded from work in open employment, and from reproductive labour in the private family sphere, such as reproducing and parenting children and maintaining a household.⁴⁰² While their exclusion from productive labour when viewed through the conventional medical lens is understood as naturally associated with their disability, when viewed instead through the lens of ableism, the exclusion of women and girls with disability can be understood as associated with being socially assigned as abnormal, unfit, unproductive and incapable and an economic burden on others, a status which individualises their circumstances and removes accountability of the state and employers to support their economic participation (including through access to reasonable accommodations in open employment workplaces, abolition of disability segregated employment, effective processes for enforcing legal guarantees of equality and non-discrimination).
- 5.62 The socially assigned status of women and girls with disability excluded from productive and reproductive labour supports the economic devaluing of their bodies as those of full citizens, legal persons and humans entitled and the emergence of other (violent) ways of extracting profit from their dehumanised bodies⁴⁰³ which also normalises and invisibilises the economic and social benefit that others derive from their exclusion. Exclusion from productive and reproductive labour means governments, businesses, charities and communities find other ways to extract labour and profit from the bodies of women and girls with disability. Profit might instead be extracted from people with disability through their subjection to forced labour and servitude. In a contemporary context this occurs through grossly underpaid labour in Australian Disability Enterprises (formerly known as ‘sheltered workshops’).⁴⁰⁴ Historically this forced labour and servitude occurred through people with disability being required to contribute to building and maintaining the disability institutions where they were detained (a practice that is yet to be fully acknowledged and redressed by the governments or organisations that operated these institutions).⁴⁰⁵
- 5.63 Beyond the conventional understanding of labour as ‘work’, extraction of profit from the bodies of women and girls with disability can also occur through the economic gains derived from their disability. For example, additional to the profit derived from the labour of women and girls with disability in Australian Disability Enterprises, the service providers operating these workplaces are also able to access NDIS funding that attaches to the support needs of the women and girls with disability (including funding to enable use of non-consensual restrictive practices) and have competitive advantages in government procurement processes because they employ people with disability. Another example is the warehousing of people with disability in large scale residential settings, group homes, residential aged care facilities and precarious housing such as boarding houses.⁴⁰⁶ Warehousing involves congregating a large number of people with disability (at a higher concentration than would occur in the community) as though they are objects being

locked away to be stored and providing care and support that is driven by organisational convenience and efficiency rather than recognition of the humanity of the individuals.⁴⁰⁷ Warehousing maximises organisational profit by reducing the expenses spent on the labour and resources for each individual without passing on these savings to the individuals receiving care or returning saved expenses to funders, at the same time that it causes emotional and physical violation and neglect, and in turn, physical pain and illness, psychological distress and even premature death of its residents.

- 5.64 The 'Medical Industrial Complex' is another concept for understanding the way in which profit is extracted from the bodies of people with disability through their disability. The concept of the Medical Industrial Complex was originally developed by Barbara and John Ehrenreich in 1969 and in that context refers to 'a network of corporations which supply health care services and products for a profit. The term is analogous to "military-industrial complex" and builds from the social precedent of discussion on that concept. Recently, Disability Justice activist Mia Mingus, uses the concept of the Medical Industrial Complex in the context of people with disability, defining it as a network of corporations, governments and charities that facilitate 'the systematic targeting of oppressed communities under the guise of care, health and safety'.⁴⁰⁸ She describes it as:

*an enormous system with tentacles that reach beyond simply doctors, nurses, clinics, and hospitals. It is a system about profit, first and foremost, rather than 'health', wellbeing and care. Its roots run deep and its history and present are connected to everything including eugenics, capitalism, colonization, slavery, immigration, war, prisons, and reproductive oppression. It is not just a major piece of the history of ableism, but all systems of oppression.*⁴⁰⁹

- 5.65 There are four implications for sexual and reproductive violence against women and girls with disability. First, women and girls with disability are not considered as worthy of allocation of resources for their sexual and reproductive health or to support them in pregnancy, childbirth and parenting. Instead, based on the assumption that others will have the reproductive labour associated with their children, violence in the form of forced and coercive interventions such as sterilisation, menstrual suppression, contraception, abortion and child removal are considered economically efficient and necessary. Second, in a context where women and girls with disability cannot contribute productive labour to the economy, profit can instead be extracted from their bodies through forced and coercive interventions in their sexuality and reproduction that minimise the cost, resources, labour and risk required to acquit the services for which they are funded. Disability services might have their female residents on menstrual suppression to reduce the time and cost involved in daily personal care, on contraception to facilitate organisational risks and additional labour (e.g., paperwork) associated with pregnancy, and they might provide sex toys rather than support access to intimate relationships or sex therapists so as to reduce the labour involved in physically and emotionally supporting women in these experiences. Disability service providers and residential aged care service providers might respond to distress and trauma experienced by women and girls with disability through restrictive practices and psychotropic medication, rather than providing trauma-informed support and access to complaint and justice processes. Third, warehousing women and girls with disability in closed, institutional settings where there is little external oversight and ineffective complaint processes facilitates unlawful sexual and physical violence against women and girls with disability. The framing of these settings as workplaces (i.e., sites of paid labour for disability service staff and in turn economic gain for disability service providers) coupled with the disposability of people with disability contributes to the trivialising and normalisation of violence:

Regardless of setting or context, violence against people with disability in Australia continues to be conceptualised, downplayed and 'detoxified' as 'abuse' or 'neglect' or 'service incidents,' or 'administrative infringements' or a 'workplace issue to be

addressed’ - rather than viewed as ‘violence’ or crimes. This is particularly the case in institutional and residential settings – including group homes, boarding houses, mental health facilities, schools and prisons - where violence perpetrated against people with disability is rarely recognised or understood as ‘violence’, and more often than not, is deliberately minimised, trivialised, ignored, dismissed, excused, covered up, or normalised.

Terms such as ‘abuse’ are often used in an effort to acknowledge that a power dynamic may be part of an assault. This detoxifies assault. It also exacerbates the existing tendency to infantilise adults with disability, because in a criminal context, ‘abuse’ is primarily used in relation to children. Similarly, the use of terms such as ‘neglect’ to describe the withdrawal of, or failure to provide, life-sustaining supports is also problematic. It can make situations where the intention is to cause death, appear ‘less violent’, and this often affects prosecution. It also affirms the narrative found in both media and criminal prosecutions that people with disability constitute such ‘burdens’ on their carers that this ‘burden’ mitigates the crime. ‘Neglect’ of children is a specific criminal offence, but its use in relation to adults can again be infantilising.

People with disability who live, occupy, and/or experience institutional, residential and service settings are regularly deprived of the information, education and skills to recognise and address violence, and are often taught and ‘rewarded’ for, unquestioning compliance. They often do not recognise the violence perpetrated against them as a crime and are unaware of how to seek help and support. Even if they are able to disclose, they are unlikely to be believed, and are often actively prevented from seeking help and support. In such settings, criminal behaviours are simply normalised. This widespread tendency to downplay and re-frame violence as ‘abuse’ or as a ‘service incident’ results in denying people with disability the legal protections and justice extended to other people. Pervasive discriminatory and ableist attitudes within police culture and the criminal justice system (including the tendency to blame the victim; refusal to investigate allegations of violence; treating crimes of violence as a ‘service incidents’; failing to make reasonable adjustments; assuming that a prosecution will not succeed because the court may think the person lacks credibility; along with negative or paternalistic stereotypes of people with disability), all contribute to the pervasive and extensive violence perpetrated against people with disability in institutional and residential settings.⁴¹⁰

The failure by disability service providers and residential aged care service providers to respond to sexual and reproductive violence against women and girls with disability might also be due to the governance structures of these services where accountability is primarily to members and/or shareholders, funders and regulators, which drives risk management and profit-driven approaches directed towards preserving the reputation, funding, registration and existence of the organisations rather than the interests of the victim-survivors. Fourth, disability service providers and residential aged care service providers might not support women and girls with disability to access the more intangible and emotional dimensions of sexuality and reproduction, such as experiences of love, intimacy, and sexual pleasure, and affective states such as happiness, joy, desire, sadness and grief, where these cannot be justified on the basis of economic utility and instrumentality. This is demonstrated by Alexander and Gomez in relation to their observations on the economic unjustifiability of pleasure in the context of disability service provision:

Pleasure is not prioritised as it should be in the lives of people with disability. In the world of dis-ability services, interactions must have a practical outcome, for example, showering, eating, and catching the bus. What workers do in a day becomes focused “activities of daily living” and “meaningful occupation”. When money is involved, outcomes need

to be clear. Anecdotally, an outcome of “increased pleasure” probably would not be adequate to justify funding. The language used in relation to people with intellectual disability becomes its own self-serving jargon. Everyday activities are described in formal terms. For example, instead of saying “going out”, we refer to people with intellectual disability as having “community access” or “social interaction”. The spirit of “normalisation” has been thwarted by the industrialisation of people with intellectual disability, wherein they become the object of care, and lose their parallel humanity in the process.⁴¹¹

5.66 Attention to the political economy of sexual and reproductive violence highlights the financial incentives and drivers for *perpetrating* sexual and reproductive violence. Yet, these economic dynamics also signal how sexual and reproductive violence becomes invisibilised and depoliticised. This is because they are so normalised in mundane, day-to-day service provision and in the less visible and operational management, governance and funding/financial dynamics of disability services and aged care services. Indeed, this sexual and reproductive violence in disability service and aged care settings can be understood as ‘slow violence’ – ‘violence that occurs gradually and out of sight’ and ‘is dispersed across time and space.’⁴¹² Slow violence ‘is typically not viewed as violence at all’ by reason of the conventional understanding of violence as ‘an event or action that is immediate in time, explosive and spectacular in space.’⁴¹³ Drawing out the dynamics of slow violence focuses attention on harms that might otherwise ‘slip under the radar’ because these harms accumulate gradually over time and are entrenched in the structural dimensions of services.

5.67 Therefore, in its work on sexual and reproductive violence, the Royal Commission should:

- analyse the political economy of sexual and reproductive violence against women and girls with disability, particularly in the context of disability and aged care service provision,
- explore the impact of neoliberalism on sexual and reproductive violence against women and girls with disability, and
- analyse the relationship between the operational management, governance and funding/financial dynamics of disability services and aged care services and sexual and reproductive violence against women and girls with disability.

Gendered Ableist Legal Violence

5.68 Understanding sexual and reproductive violence against women and girls with disability through the lens of ableism encompasses exploration of the legal dynamics of violence. This is necessary because many forms of violence against women and girls with disability are lawful in the sense of being enabled and regulated, rather than prohibited and redressed, by legal and justice systems. Thus, we include in our conceptual approach the notion of gendered ableist ‘legal violence’ to help understand how sexual and reproductive violence becomes non-violent and just; how women and girls who experience these violations are further dehumanised by the failure of legal and justice systems to recognise these violations as unlawful violence; and how they are denied the status of victims-survivors of violence entitled to redress.

5.69 ‘Legal violence’ is the regulation or permitting (rather than total prohibition) of interventions of individuals’ bodies and lives by legal doctrine and legal decision-makers.⁴¹⁴ The idea of legal violence has its basis in the notion that all law is inherently violent⁴¹⁵ and that physical

force is implicated in (rather than external to and in absolute opposition to) law. At the core of the concept of ‘legal violence’ is a relationship between the ‘word’ of law (that is, the legal interpretation and the resulting judgment and court order) and a ‘deed’ of violence itself (that is, the act of non-legal/judicial actors administering the order).⁴¹⁶ An example offered by US legal scholar Robert Cover is criminal punishment. Criminal punishment in the form of incarceration and loss of liberty can be analysed as legal violence because the punishment meted out by prison officers is done pursuant to the terms of the words of the judge’s sentence, and it is because the act of punishment is constrained by the words of this legal order that it is a legitimate use of violence in being fair, humane, just and non-arbitrary.⁴¹⁷

- 5.70 Steele offers the concept of ‘disability-specific lawful violence’ to refer to forced and coerced interventions in the bodies and lives of people with disability that are permitted by law specifically on the basis of disability (or characteristics associated with disability, such as mental incapacity).⁴¹⁸ Examples of disability-specific violence in relation to sexual and reproductive violence include forced sterilisation, abortion, contraception and menstrual suppression as well as restrictive practices to prevent sexual or intimate relationships.
- 5.71 Ordinarily, interventions in people’s bodies and lives that are non-consensual (and without other lawful authority) would amount to unlawful violence in the form of criminal or civil assault or false imprisonment. A victim-survivor of such interventions would be entitled to seek criminal justice assistance and civil remedies for compensation and other forms of redress. However, in the context of disability-specific non-consensual interventions, criminal offences or civil causes of action will not be made out because a court or tribunal has ordered the intervention or authorised a third party to consent to the intervention. In being regulated through disability-specific jurisdictions and legal doctrine, these interventions demonstrate how segregation in legal and justice systems exposes people with disability to additional forms of violence compared to people without disability.⁴¹⁹
- 5.72 Disability-specific lawful violence is positioned in legal doctrine as necessary in order to provide women and girls with disability with protection, treatment or, in a contemporary context, to empower them by facilitating the possibility of their future inclusion, participation and autonomy.⁴²⁰ Thus, disability-specific lawful violence is represented as non-violent and just. Yet, there is a fundamental perversity in securing purportedly benevolent ends through violence.⁴²¹ This perversity is particularly apparent when such violence gives rise to harms ‘endured through the non-consensual interventions themselves and in the denial of autonomy and failure to acknowledge the worldview of disabled people’ and these harms ‘can far exceed that which the intervention was trying to prevent’.⁴²²
- 5.73 Representations of disability-specific lawful violence as necessary, non-violent, and just are particularly pernicious in the context of non-consensual interventions into the bodies and lives of First Nations people with disability. These disability-specific interventions ‘can expand and mask settler colonial control and violence towards Indigenous and First Nations peoples and other racialised minorities because of the therapeutic and medical means’ through which they occur⁴²³ and ‘the therapeutic and medical connotations associated with disability’.⁴²⁴ Moreover, the necessity of these interventions as rationalised on the basis of protecting First Nations people with disability or acting in their best interests echoes centuries of settler colonial legal violence that has enabled dispossession, displacement and genocide through its ‘staging of Indigenous pathology and dysfunction’ and the state as ‘benevolent’.⁴²⁵
- 5.74 The disability-specific legal violence of some forms of sexual and reproductive violence against women and girls with disability, highlights how gendered ableism is built into the doctrine (rather than merely the application) of law. Yet, even deeper than legal doctrine,

this gendered ableism is also built into foundational legal concepts that structure legal rights and legal relations, such as ‘capacity’ and ‘consent’. Therefore, a conceptual approach that includes legal violence, illuminates the complicity of *law, justice systems and the State at individual and structural levels* in sexual and reproductive violence against women and girls with disability. There can be no *justice* through legal and justice systems when these very systems are complicit in the perpetration of *injustice*. It will be deeply troubling and disappointing if the Disability Royal Commission does not confront and reckon with law’s role in sexual and reproductive violence. This has three key implications.

- 5.75 First, segregation in legal and justice systems that underpins disability-specific legal violence gives rise to dehumanisation, as explained by Roper et al. in the specific context of mental health laws:

Dehumanisation involves viewing individuals through a particular lens, labelling them, othering and systematic exclusion ...

Mental health laws are symbolic of dehumanisation because they create a legal space that is outside the scope of justice, where operations of human rights and ethics afforded to other human beings are suspended. ... These laws symbolically declare individuals governed by them to be ‘morally irresponsible’, and in the process, the laws are positioned as enabling the provision of benevolent and protective care. In the application of mental health laws, decisions about who gets to keep their human rights and who does not happen through someone else declaring whether or not we are capable of consenting to treatment. If deemed to lack capacity to consent, under mental health laws we are governed by this ‘other’ legal space, we are no longer part of the moral community, we are not moral, thinking persons, we have been legally defined as non-thinking, non-feeling.⁴²⁶

- 5.76 Moreover, segregation of legal and justice systems underpinning disability-specific legal violence impedes women and girls with disability benefiting from progressive law reforms pertaining to sexual and reproductive violence. This is demonstrated by law reform in some states and territories on abortion which focuses exclusively on reforming crimes legislation that criminalises women for accessing abortion,⁴²⁷ while leaving unreformed the *absence of criminalisation* of forced and coercive abortion, contraception and sterilisation of women and girls with disability pursuant to disability-specific law.

- 5.77 Second, it is important to note that the ableist legal concept of capacity that underpins legal regulation of forced and coerced, abortion, contraception and menstrual suppression is deeply embedded within the structure of the Australian legal system and understandings of the rule of law (notably in terms of defining the limits of the legal system in relation to people with capacity). Consequently, abolishing sexual and reproductive violence against people with disability will require transformative change of the entire legal system and broader consideration of the touchstones of legality and justice.⁴²⁸

- 5.78 Third, legal and justice systems contribute to epistemic violence against women and girls with disability. Laws enabling forced sterilisation, abortion, contraception and menstrual suppression contribute to hermeneutical epistemic injustice (discussed above in the context of epistemic injustice) in failing to provide the interpretive tools to see these interventions as violence. Legality of forced and coerced sterilisation, abortion, contraception and menstrual suppression contributes to the normalisation of violence and control in disability service and residential aged care service contexts, making it more difficult for individuals to understand when harmful behaviour is wrong and unjust. Further, law compounds the epistemic injustice associated with the enacting of these interventions, because laws authorising third party consent to restrictive practices explicitly remove from people with disability both the opportunity to express their wishes for their bodies and lives

and the opportunity to have this recognised by others. Moreover, laws excluding some individuals who authorise or engage in these interventions from criminal responsibility and civil liability categorically deny people subject to third party consent the opportunity to voice their violation in criminal and civil justice systems, thus giving rise to a state of ethical loneliness.

5.79 Therefore, in its work on sexual and reproductive violence, the Royal Commission should:

- analyse the complicity of legal doctrine and justice systems in enabling and regulating sexual and reproductive violence against women and girls with disability,
- analyse the role of conventional understandings of law as humane and protective towards people with disability in legitimating legal sexual and reproductive violence against women and girls with disability, and
- analyse the gendered ableism grounding the legal frameworks for enabling and regulating sexual and reproductive violence against women and girls with disability.

Sexual and Reproductive Justice

5.80 In the final part of this section we build on our principled and conceptual approach to sexual and reproductive violence against women and girls with disability, by turning to conceptualise an approach to thinking through sexual and reproductive justice for women and girls with disability.

5.81 The lens of ableism highlights how conventional understandings of individualised legal justice accommodate and legitimate sexual and reproductive violence against women and girls with disability. Disability rights activists and critical disability scholars highlight that ableism is embedded in legal and justice systems. This shapes and limits how violence is defined, who is recognised as a victim of violence and who can be held accountable for violence, who is recognised as a legal subject in court, whose experiences are recognised as evidence or as admissible or reliable evidence, and how remedies are determined and compensation calculated.⁴²⁹ Conversely, legal and justice systems determine whose bodies are legitimately disposable and violable, which bodily interventions will not be recognised as violence and injustices, who will not be recognised as a victim of violence, who will not be held accountable for violence, and who will not be recognised as a legal subject in court or as capable of giving admissible or reliable evidence. Ultimately, legal and justice systems currently enable sexual and reproductive violence to be perpetrated against women and girls with disability and facilitate a lack of accountability and redress in the aftermath of such violence.

5.82 The lens of ableism is also useful in interrogating the limits of legal reforms to the regulation of consent and decision-making, suggesting that these alone will not address the full scope of sexual and reproductive violence. For example, Jess Whatcott argues that understanding ‘problems in terms of legality and illegality’ is too narrow and fails to ‘produce justice’, purposing instead that we must ‘explode our current political imaginaries out of the binaries of legal/illegal, and even legalistic notions of justice/injustice’.⁴³⁰ Writing in the context of the limits of informed consent as a basis of reproductive justice for women in prison, Whatcott, argues:

Informed consent purports to protect vulnerable people from coercive sterilization. However, because biopolitical power persists in spite of or in adaptation to regulations

*put in place in the name of ending coercive sterilization, informed consent has functioned largely as a reformist reform that works to consolidate carceral regimes.*⁴³¹

- 5.83 In particular, in the institutional setting of prison, informed consent is meaningless because the broader carceral conditions in which people are incarcerated undermines the very possibility of autonomy that is necessary to exercise informed consent. In making this argument, Whatcott draws on the work of Lisa Marie Cacho on ‘social death’, which is a

*spatial and temporal realm ... where people are not eligible for legal recognition of civil and political rights or for public empathy for their dispossession of these rights—nor is it possible to value their lives and resistance under the imperatives of biopolitics. The social death thesis indicates that non-coercive consent is not actually possible for people who are locked up, because the disavowal of their agential and autonomous personhood constitutes the very ground on which the notion of consent is consolidated. ... the denial of personhood to people imprisoned in women’s prisons, including the denial of their individuality, agency, autonomy, and ability to consent, is formulative of these concepts in the free world outside of the prison.*⁴³²

- 5.84 Whatcott’s observations are relevant to women and girls with disability, in light of the pervasive role in their lives of institutionalisation, segregation, restrictive practices and informal control by family and service providers, coupled with the cultural and legal denial of their personhood.
- 5.85 Thus, the lens of ableism highlights that realising individualised legal justice as one part of sexual and reproductive justice involves challenging ableism and disposability within legal and justice systems and ending segregation of legal and justice systems, as has been argued by DPOA in its campaign to ‘#EndSegregation of People with Disability’.⁴³³
- 5.86 Yet, the lens of ableism highlights that individualised legal justice by itself is limited in addressing sexual and reproductive justice. Steele reflects that:

*While it is absolutely important individuals have access to remedies for specific harms, it is also vital to resist exclusively individualised remedial approaches that cannot comprehend structural, historical and intergenerational harms—particularly those associated with settler colonialism—that exceed a singular victim and perpetrator.*⁴³⁴

- 5.87 Thus, the lens of ableism supports an approach to sexual and reproductive justice that looks beyond individualised legal justice through courts to explore alternative understandings, practices and forums of justice as the basis for a more expansive approach to sexual and reproductive justice that addresses individual and collective harms and transforms structural dynamics driving violence.
- 5.88 As WWDA has argued for a number of years,⁴³⁵ approaches to justice which are often collectively referred to as ‘transitional justice’ might also provide understandings of justice that capture intergenerational, historical, and structural injustices, whilst also eliciting collective and community-based responses. Transitional justice approaches have emerged in the context of responses to mass harms perpetrated by or in complicity with governments or justice systems - such as armed conflict, genocide, slavery and colonialism. Transitional justice approaches have been utilised in relation to sexual and reproductive violence enacted against marginalised groups, although their application to women and girls with disability requires deeper exploration.⁴³⁶ Balint, Evans, McMillan and others build on transitional justice approaches in proposing the concept of ‘structural justice’ as a framework ‘based on historical consciousness and a recognition of the enduring significance of the past; discursively and practically manifest’⁴³⁷ and as ‘a fundamentally relational phenomenon, grounded in openness and engagement’.⁴³⁸ Drawing on transitional justice and structural justice approaches to explore and articulate sexual and

reproductive justice might provide tools for understanding justice as involving ongoing processes and relations of accountability that involve governments, service providers, legal, health and social care professionals and the wider community.

- 5.89 Intersecting with transitional and structural justice, drawing on the lens of ableism to understand sexual and reproductive justice illuminates the need to respond to historical injustices as part of a broader framework of state and community accountability. Critical disability scholars Chapman, Carey and Ben-Moshe pose two questions. First, they ask ‘[h]ow can there be accountability today’ to disabled people who have experienced violence (including fatal violence) in the past? They describe these past injustices as ‘hauntings that need to inform politics, policies, activism, and scholarship today — real people who lived and died confined, or with the threat of confinement shaping the possibilities for their lives’. Second, they ask ‘how can we live in a way that is also accountable ... to those “not yet born?” ... This future “yet to come” ... is a looming presence that has to be lived with, that has to be contended with, today’.⁴³⁹ Attention to historical injustice and its connections to contemporary violence is particularly necessary in the context of sexual and reproductive justice because of the histories and hauntings of past perpetration of forced sterilisation and sexual violence and other forms of violence in largescale disability institutions which have not yet been officially acknowledged or redressed.
- 5.90 The lens of ableism also highlights that an understanding of sexual and reproductive justice must not work within a disability-specific justice silo. Instead, sexual and reproductive justice should be directed towards addressing and redressing sexual and reproductive violence within the contextual dynamics and forces of interlocking oppressive systems and grounded in broader historical, economic, and geopolitical dynamics. To this end, it may be useful to draw on the reproductive justice framework. This has been defined as:

both a theoretical paradigm shift and a model for activist organizing centring three interconnected human rights values: the right not to have children using safe birth control, abortion, or abstinence; the right to have children under the conditions we choose; and the right to parent the children we have in safe and healthy environments. RJ activism is based on the human right to make personal decisions about one’s life, and obligation of government and society to ensure that the conditions are suitable for implementing one’s decisions. ... In particular, RJ draws attention to the current lack of physical, reproductive and cultural safety. It focuses on structural oppression and the development of new theories and activism to create radical pathways of resistance and strategies for change that incorporate the complexities of our diverse economic, racial, gendered, cultural, and geographic locations. ... To obtain RJ, we must work on injustices in all arenas: social, economic, gender, racial, environmental, financial, physical, sexual, environmental, disability, and carceral.⁴⁴⁰

- 5.91 While reproductive justice emerged out of African American women’s activism and has historically been applied to the contextual experiences of racialised women in the United States of America, disability rights activists and critical disability scholars are applying reproductive justice in the context of women and girls with disability.⁴⁴¹ The reproductive justice framework is useful in highlighting the compounding dynamics of injustice and violence – across history, generations, domains of reproduction (e.g., abortion, child removal, sexual violence), marginalised communities, and government systems) that need to be transformed at a structural level to ensure ongoing equality, flourishing and security at the individual and community level. Importantly for our purposes, reproductive justice approaches justice as requiring an end to coercion, including coercive practices in institutional systems:

Reproductive justice clarifies the need for protection from coerced sex and reproduction and also from coerced suppression or termination of fertility. The

*reproductive justice/human rights framework makes claims on the incarceration system, the immigration system, and the health care system, for example, to block institutional degradations associated with fertility, reproduction, and maternity or parenthood, and to recognize and protect the reproductive health and parenting rights of persons under their purview.*⁴⁴²

- 5.92 Drawing on the lens of ableism to understand sexual and reproductive violence directs attention to the importance of abolition of all systems of confinement and control of people with disability. Abolition may be conventionally (and often intentionally) misunderstood as simply obliterating existing prison-like systems or practices, leaving it conceptually prone to being criticised for not offering alternatives or for leaving people to fend for themselves. However, this is a misconception of ‘abolition’, one that conveniently feeds back into the perceived necessity of systems of confinement and control as the only option. Instead, Ben-Moshe explains that abolition consists of three components: ending existing prison and prison-like structures, reconceptualising oppression within prison and prison-like spaces, and developing and implementing a strategy that promotes the creation of a more equitable, safe and just society.⁴⁴³ Ben-Moshe argues that abolition takes an epistemological orientation that is not focused on certainty and prescription, its goal instead is ‘therefore not finality but process itself, trial and error, and in understanding disorientation as generative’.⁴⁴⁴ Liat Ben-Moshe elaborates:

*Abolition ... not only acknowledges [and resists] the structure as is, but envisions and creates a new worldview in which oppressive structures do not exist. It goes beyond protesting against the current circumstances to envisioning a more just and equitable world. Abolition can take the form of tearing down the walls of the prison, psychiatric hospital and institution. It is also about building alternatives to incarceration: supporting community living for all, developing affordable and accessible housing, and countering capitalism, ableism, racism, transphobia, and ageism in order to achieve a world in which carceral [prison-like] spaces are meaningless and unnecessary. Abolition enables us to engage in politics of the future... It is not just the conceptualization but also the active pursuit of a non-carceral future.*⁴⁴⁵

- 5.93 In bringing together the projects of abolition and feminism, Angela Y Davis et al propose rejection of ‘state attempts to mobilize vulnerability and difference for the purpose of expanding carcerality and instead works to highlight the role of the state in perpetuating violence, demanding engagements that both support people who are most affected and address the root causes of incarceration – poverty, white supremacy, misogyny’.⁴⁴⁶
- 5.94 Deinstitutionalisation (the closure of largescale residential institutions for people with disability) has been a cornerstone of the disability rights movement⁴⁴⁷ and is an important component of sexual and reproductive justice. However, Disability Justice activists and some critical disability scholars take a broader approach in light of the interlocking systems and practices of confinement and control of people with disability; having been responsible for producing abolitionist theory and frameworks in the disability community. For example, Disability Justice activist Mia Mingus recognises the reality of the current dependency of many people with disability on the Medical Industrial Complex but suggests this dependency comes out of a lack of alternatives:

We are not saying that there are no useful or helpful things within the MIC. It has saved many of our lives or the lives of people we love. We are not anti healthcare or science, but are rather exposing the reality that many of us are dependent on the MIC while we are simultaneously trying to change it and ultimately build alternatives to it. Many of us don't want to have to turn to the MIC, yet have few other viable options. And still many of us are fighting for access to current (or better) services within the MIC. There are no easy answers and the contradictions we are living in are often painful and unjust. Similar to our work to resist and challenge capitalism or to create

*alternatives to the police and prisons, resisting and challenging the MIC is rife with complexity and there is so much we need that we don't have yet.*⁴⁴⁸

- 5.95 Mingus thus argues for us to 'dream and invest in building alternatives. We have so much shared ground when it comes to being able to answer the ever-present question, "What could true wellness and care look like for our communities?"'.⁴⁴⁹ In a similar vein, critical disability scholars Chapman, Ben-Moshe and Carey argue for the dismantling of the 'institutional archipelago', introduced earlier in this section.⁴⁵⁰ The Abolition and Disability Justice Collective proposes an approach to abolition that encompasses criminal justice and social care systems:

Abolition is not limited to ending spaces and practices of incarceration and policing. Fundamentally, abolition is also about reimagining new ways of life such that a world in which prisons, policing and other carceral systems as solutions to social problems becomes unthinkable. Abolitionism is also not just about creating new responses to crises but creating a new world in which we thrive such that less crises happen in the first place.

Prisons and policing are not the only carceral systems. Investing in social work and psychiatric agencies is often framed as an "alternative" to policing and prisons. But mental health systems are also carceral and punishing. At the hands of these so-called "gentler" policing systems, people who are Neurodivergent and/or Disabled are simultaneously non-consensually subjected to violence, incarceration and discrimination, and also excluded from shaping decisions directly impacting our lives.

Abolitionists coined the term "prison industrial complex" to highlight that the problem is not just individual prisons, but that our capitalist economic system is structured through institutions of punishment. Similarly, we must also end the medical industrial complex that is structured, not on systems of care, but rather on profit. Thus, an abolitionist perspective rooted in disability justice must also be anti-capitalist.

*We must not reproduce the very systems we are trying to abolish. The solutions we need require centering the needs, ideas and testimonies of intersectionally vulnerable people to create the life-affirming communities we desire and deserve.*⁴⁵¹

- 5.96 TL Lewis explains the importance of taking a broad approach to carcerality:

*When abolitionists do not have a strong disability justice analysis, systems of incarceration simply recategorize and redistribute people into other violent carceral institutions for other manufactured reasons — often based on purported health, criminality, and vulnerability. Knowing this, we are left no choice but to view carcerality much more broadly, through a disability justice lens. If we fail to fill this gap in our collective consciousness, ableism will continue to be used as an excuse for inflicting violence upon marginalized people under the guise of care, treatment, and rehabilitation.*⁴⁵²

- 5.97 The abolitionist approach aligns with the DPOA campaign to '#EndSegregation of People with Disability' which observes the failure of reformist approaches to address ongoing segregation and incarceration of people with disability and the ableism that underpins these practices:

Despite these important disability reforms, ableism remains entrenched in existing Australian law, policy and practice frameworks. These frameworks often reference the CRPD and aim to implement human rights obligations to ensure the inclusion of people with disability in all aspects of community life. However, this has not always translated into action to achieve genuine human rights for people with disability. In many cases, it has only resulted in action to enhance existing systems, rather than

challenging the ableism at the core of these systems. The reform of existing systems only serves to normalise, legitimise and reinforce the continuation of segregation of people with disability.

Support for segregated systems is too often justified by ableist assertions and cloaked by the language of ‘benevolent paternalism’, such as being ‘in our best interests’, for ‘our safety and protection’, to address ‘high support and complex needs’, to respond to ‘severe and profound impairment’, to manage ‘challenging behaviours’, to prevent ‘risk of harm to self and others’ and to address the lack of alternative options and resources. Segregated systems are often supported by well-established funding and vested interests in disability, education, mental health, aged care and other service systems, with the purpose, existing financial arrangements and status of these systems privileged over the rights of people with disability.⁴⁵³

5.98 Abolition of these networks of confinement and control are central to understanding sexual and reproductive justice for women and girls with disability, even though these systems are not specifically focused on sexuality and reproduction. For example, Whatcott (discussed earlier in this section) argues that in order to address forced and coercive sterilisation of women in prison and realise reproductive justice, a transformative abolitionist approach is required to dismantle the broader biopolitical power and social death that women are subjected to in prison.⁴⁵⁴ Whatcott states: ‘reproductive justice for imprisoned people demands an alignment with the vision of prison abolition. Only by seeking a future without walls and cages can we hope to dismantle biopolitical power and carceral population politics’.⁴⁵⁵ Winters and McLaughlin argue that ‘reproductive autonomy is not possible without the destruction of the carceral state’.⁴⁵⁶ Thus, abolitionism is transformative in material and epistemological senses as it functions to transform the actual material experiences available to women and girls with disability, while also changing the way we think about what is possible in life for women and girls with disability. The absence of ‘alternatives’ for sexual and reproductive violence (particularly disability-specific legal violence) is partly caused by a failure of imagination to think beyond the parameters set by existing cultural understandings of disability.

5.99 Considering through the lens of ableism the financial *enrichment* to disability and aged care services associated with sexual and reproductive violence highlights that *preventing* violence must involve dismantling economic structures that provide profit and financial incentives to enact this violence and challenging the disposability of people with disability that renders their disability a source of violent economic extraction. Moreover, *redressing* this violence must not only attend to recognition and repair of the harm and loss experienced by women and girls with disability, but also extend to accountability for financial enrichment of perpetrators and third parties related to the financial gain arising from sexual and reproductive violence.

5.100 Sexual and reproductive justice is not simply about having the opportunity to fulfil heteronormative roles of mother and wife, nor only about ensuring protection from gender-based violence. Rather, it also encapsulates being recognised as sexual subjects, as agents and objects of desire and pleasure, as disability rights activist Jax Jacki Brown states:

So what does access mean when we talk about sexuality and disability? What do rights mean?

- It means creating accessible sex education that incorporates pleasure and strength-based elements: that speaks to what we can and want to do with our bodies.*
- It means supporting people with disability to demand respect in relationships and sexual encounters.*

- *It means creating sex-positive accessible spaces and venues.*
- *It means proclaiming our bodies as desirable – this is a political act.*
- *It means rejecting traditional gender roles and ideas about sexuality*
- *It means making forced and coerced sterilisation illegal.*
- *It means making forced contraception illegal.*

Eli Clare, a disability activist says it means creating “...places where we encourage each other to swish and swagger, limp and roll, and learn the language of pride. Places where our bodies become home”.

“For me, the key to enacting sexuality rights as a person with disability is I think, learning to call my body home, to inhabit it fully, just as it is. Too often many of us have been taught to distance ourselves from our bodies, to feel ashamed. It is time to call our bodies home, to feel what it feels like to be in this body, and to do so proudly, boldly and unapologetically.”⁴⁵⁷

5.101 Sexual justice and sexual citizenship approaches with their focus on sexual identity, expression and pleasure can also be drawn upon to complement the focus on fertility, pregnancy and parenting in the reproductive justice framework. These approaches are particularly important to avoiding paternalistic, moralistic or medicalistic approaches to disability and sexuality, as has been flagged in the context of international human rights. Hannah Ginn explains that promoting ‘sexually just futures’ for people with intellectual disability requires a radical and transformative approach that centres the dynamics of control in services, professionals and families: ‘it is important to reorient attention from changing people whose socio-sexual lives are circumscribed by the agencies, professionals and family members to the constraining forces themselves’.⁴⁵⁸ She explains

Enabling people’s wishes for their sexual expression and relationships allows them to explore, take risks and make meaning of this aspect of their lives rather than being subject to a managerial framework that prescribes attitudinal and behavioural norms as well as limited boundaries of sexual and relational opportunities.⁴⁵⁹

In this respect, there is an intersection of sexual justice and abolition, insofar as sexual justice requires dismantling of carceral practices and knowledges that shape and limit sexual possibilities for women and girls with disability. On a related note, sexual justice should also ‘challenge economic injustice along with the denial of sexual rights’ in order to prevent sexual rights being subsumed within neoliberal frameworks that make access to equality in sexual pleasure and expression economically contingent.⁴⁶⁰

5.102 Therefore, in its work on sexual and reproductive violence, the Royal Commission should:

- explore how preventing and responding to sexual and reproductive violence as one component of a broader approach to justice which also includes fostering positive and empowering sexual and reproductive experiences,
- explore how to end broader practices of segregation, incarceration, control and inequality that provide many of the conditions for sexual and reproductive violence to flourish,
- explore how justice can be achieved at the individual and structural levels, and through and beyond legal and justice systems,
- analyse the economic dimensions of sexual and reproductive justice, including

ways to ensure accountability for the financial gain to perpetrators and other beneficiaries of sexual and reproductive violence,

- explore how to address and redress sexual and reproductive violence that is historical, and
- explore how to address and redress ableism within legal and justice systems, as a necessary prior step to engaging legal and justice systems to realise justice.

Section 5 Conclusion

5.103 What we have presented in this brief discussion are some of the building blocks of a principles and conceptual approach to sexual and reproductive violence and justice that is centred on the lens of ableism. In Section 6, we turn to explore lived experiences of sexual and reproductive violence and the laws, politics and cultural expressions of ableism that enable such violence specifically in our Australian context. This in-depth analysis of forms and examples of sexual and reproductive violence in Australia is conceptually informed by the framework set out above and forms the bedrock of the recommendations set out in Section 1. Particularly we intend to highlight to the Royal Commission, how sexual and reproductive justice frameworks can shift our approach to transformative change and redress in a way that is effective, holistic and meaningful.



6 LIVED EXPERIENCES, LAWS AND PRACTICES OF SEXUAL AND REPRODUCTIVE VIOLENCE IN AUSTRALIA

6. LIVED EXPERIENCES, LAWS AND PRACTICES OF SEXUAL AND REPRODUCTIVE VIOLENCE IN AUSTRALIA

6.1 This section discusses some of the current circumstances of sexual and reproductive violence against women and girls with disability in Australia. This section is structured by reference to key domains of sexuality and reproduction: menstruation and reproduction, sexual identity, expression and activity, sexual and reproductive health, pregnancy, and parenting. In discussing experiences of women and girls with disability through these domains, we draw on existing empirical research and narratives from Australian scholarship and advocacy reports. However, in light of the dearth of empirical research (discussed in Section 2), we also note research from other jurisdictions which indicates areas that should be further explored in the Australian context by the Royal Commission, either as part of its research agenda or through its coercive and investigative powers. That said, our general observation is that critically-oriented empirical research across the entire area of sexual and reproductive violence is currently lacking, and thus the Royal Commission should prioritise this area of violence in its research and investigation. We also discuss some of the legal frameworks that shape the structural conditions for sexual and reproductive violence in Australia.

6.2 As we will show in this section, women and girls with disability are denied their full range of sexual and reproductive rights through their exposure to gendered ableist violence in relation to their menstruation and reproduction, their sexual identity, expression and activity, their intimate relationships, and in pregnancy and parenting. They experience barriers to accessing justice in response to this violence, and often, the violence itself is enabled and regulated by legal and justice systems. Sexual and reproductive violence reflects, and contributes to, the dehumanisation and disposability of women and girls with disability such that their bodies and lives that do not matter.

6.3 Sexual and reproductive violence against women and girls with disability in Australia can be understood as one part of broader experiences of ableism across their lives and life courses. Frohmader and Sands explain that ableism is apparent throughout Australian society:

Ableism contributes to profound and intersecting discrimination experienced by people with disability in Australia, evidenced for example, in the following ways:

- *Social welfare policies that demonise or blame people with disability, often leading to further poverty and lack of financial independence;*
- *Stereotypes and myths, reinforced through media that marginalise people with disability by constructing disability as child-like, burdensome, tragic, dangerous, incapable, extraordinary, sexless, genderless or hypersexual;*
- *The legacy of eugenic policies and practices that promote or fail to prevent forced treatment (such as forced sterilisation and forced use of chemical or other restraints);*
- *Policy responses and strategies that assume the experience and impact of disability is homogenous and static, rather than diverse and variable over time and context;*
- *Consultative policy processes that presume able-bodiedness and in doing so, exclude a range of voices and lived experiences;*
- *Historical and cultural myths about people with disability that function to limit meaningful participation opportunities, decision-making, and representation;*

- *Structures, institutions and practices that fail to account for the intersectional, multiple and fluid nature of people’s identities and experiences;*
- *Employment structures, policies and institutions that do not account for the diversity of peoples bodies and experiences;*
- *Educational institutions and policies that privilege particular ways of learning and teaching which exclude a range of bodies and identities;*
- *Ableist immigration policies;*
- *Ongoing institutionalisation of people with intellectual disability;*
- *Built environments and public spaces that fail to account for the diversity of people’s bodies;*
- *Lack of research data and research interest into the prevalence, extent, nature, causes and impact of violence against people with disability in the range of settings in which they reside or receive support services;*
- *Unequal distribution of power and resources and institutional, cultural and individual support for (or weak sanctions against) gender inequality;*
- *Adherence to rigidly defined gender roles expressed institutionally, culturally, organisationally and individually that privilege a myth of able-bodiedness;*
- *Policy conceptualisations and responses to violence against women that do not account for the disproportionate, multiple and intersecting forms of violence that women and girls with disability experience and the spaces in which that violence occurs;*
- *Lack of awareness and understanding of the extent, nature, incidence, and impact of gendered disability violence at the individual, community, service provider, and criminal justice system levels.⁴⁶¹*

6.4 Sexual and reproductive violence experienced by women and girls with disability in Australia can be situated in broader experiences of gendered ableism, as has been articulated by WWDA:

Women and girls with disability are more likely than men and boys with disability (and other women and men) to face medical interventions to control their fertility, and experience significantly more restrictions, negative treatment, and particularly egregious violations of their sexual and reproductive rights. They experience, and are more exposed to practices which qualify as torture or inhuman or degrading treatment, including state sanctioned practices such as forced sterilisation, forced abortion, and forced contraception.

Compared to others in the population, they are more likely to be isolated and segregated within the range of settings in which they reside, are incarcerated, or receive support services; are subjected to multiple forms and varying degrees of ‘deprivation of liberty’ and are more likely to be subjected to unregulated or under-regulated restrictive interventions and practices, often imposed as a means of coercion, discipline, convenience, or retaliation by others. Indigenous women with disability are at risk of being detained indefinitely, often without conviction, in prisons and in forensic psychiatric units throughout Australia enduring periods of indefinite detention that in some cases exceed years.

Women with disability in Australia have less power and fewer resources than other

women and men. They are much more likely to live in poverty than people in the general population; have to work harder to secure their livelihoods; have less control over income and assets, and have little economic security. They are much more likely to be unemployed than other women and men with disability; less likely to be in the paid workforce; have lower incomes from employment; are more likely to experience gender and disability biases in labour markets; and are more concentrated than other women and men in precarious, informal, subsistence and vulnerable employment.

Compared to men with disability and other women, disabled women experience substantial housing vulnerability, are more likely to experience and face homelessness, and are much more likely to be affected by the lack of affordable housing. They are more likely to be sole parents, to be living on their own, or in their parental family than disabled men, are at higher risk of separation/divorce than men with disability and often experience difficulty maintaining custody of their children post-separation/divorce.

Like many women, disabled women share the burden of responsibility for unpaid work in the private and social spheres, including for example, cooking, cleaning, and caring for children and relatives. Women with disability are much less likely to receive service support than other women and men with disability, across all service types and sectors.⁴⁶²

- 6.5 Discrimination and exclusion experienced by women and girls with disability can, in turn, be situated in broader practices and systems of segregation in Australia. As is noted by DPOA in the context of its campaign '#EndSegregation of People with Disability' segregation is often framed in terms of benevolence and protection and is often supported by those who profit or otherwise benefit from their existence:

Support for segregated systems is too often justified by ableist assertions and cloaked by the language of 'benevolent paternalism', such as being 'in our best interests', for 'our safety and protection', to address 'high support and complex needs', to respond to 'severe and profound impairment', to manage 'challenging behaviours', to prevent 'risk of harm to self and others' and to address the lack of alternative options and resources. Segregated systems are often supported by well-established funding and vested interests in disability, education, mental health, aged care and other service systems, with the purpose, existing financial arrangements and status of these systems privileged over the rights of people with disability.⁴⁶³

- 6.6 Inaction on sexual and reproductive violence is sustained by the legal, political and social denial of autonomy, voice and agency of women and girls with disability. This denial invalidates their experiences of violence and excludes them from the discussions about responses and solutions to violence, reflecting our discussion of epistemic violence in Section 5:

[Women with disability] continue to represent one of the most excluded and marginalised groups of women, subject to widespread discrimination, systemic prejudice, paternalistic and ableist attitudes that denigrate, devalue, oppress, limit and deny their potential and their rights and freedoms. They are often not afforded dignity, recognition, respect, agency and/or autonomy. Regrettably, women and girls with disability in Australia continue to be denied the right to participate in, and remain largely excluded from, decision-making, participation and advocacy processes, about issues that affect their lives and those of their families, communities and nations. Too often, they have their views ignored or disregarded in favour of 'experts', 'professionals', parents, guardians, and carers, as well as representatives of organisations not controlled and constituted by people with disability themselves.⁴⁶⁴

6.7 Denial of autonomy, voice and agency to women and girls with disability, coupled with their segregation, discrimination and exclusion, impacts the opportunities to make their own choices about their bodies and lives. This has been noted by leading Australian self-advocate Judy Huett:

Other people often make decisions for us and about us. We are not always listened to. We are not always taken seriously.

Our parents can sometimes be too over-protective of us. They want to control our lives.

A lot of people treat us like we are babies or little children.

We are not allowed to take risks.

We are not allowed to do the everyday things that other women and girls do and take for granted.

People sometimes don't believe us when we tell them things.

Sometimes they don't believe us when we tell them things about people who have hurt us or that we need help to be safe.

The situation is much worse for women and girls with disabilities who live in institutions. I have got friends who live in institutions:

- Their rights are taken away.*
- They cannot choose who they live with.*
- They do not choose what time they go to bed or what time they get up.*
- They don't get to choose what time they eat, or even what they eat.*
- They are expected to fit in with the routine of the institution*
- They don't get to choose what they wear or what is in their wardrobe.*
- They can't go out when they want to.*
- They aren't allowed to learn about sex or explore their sexuality.*
- They aren't allowed to have a sexual partner.*

Many women and girls with disability in institutions have no friends and family and the only people in their lives are the people who work there.

If you live in an institution it is hard to learn how to be part of the community and have choices like everyone else.

For some women and girls with disabilities, it is very hard for them to speak up or make their own decisions, especially if they have never had the chance. They need chances to practice making choices.⁴⁶⁵

6.8 We now turn to consider in greater detail specific domains of reproduction and sexuality.

Menstruation and Reproduction

- 6.9 Women and girls with disability are subjected to violence in the context of their experiences of menstruation and reproduction.
- 6.10 Some of this violence manifests as forced, non-consensual and coercive physical, chemical and surgical interventions in their bodies, notably sterilisation, contraception and menstrual suppression. At other times the violence manifests as failures to provide any and/or appropriate services and resources to support women to have positive experiences of menstruation and reproduction.
- 6.11 While forced sterilisation, contraception and menstrual suppression do constitute violence, they are forms of violence that are legally authorised and regulated rather than prohibited. Sterilisation, contraception and menstrual suppression also take place illegally (in the sense of being without legal authorisation), including in circumstances of coercion. Coercion in relation to menstruation and reproduction of women and girls with disability can operate at individual and structural levels, as is illuminated by Marie Stopes Australia definition of reproductive coercion:

Reproductive coercion is exercised in two domains:

1. The interpersonal: the intentional, controlling behaviours that are directly exerted on a person's reproductive health by another person or persons.

2. The structural: the social, cultural, economic, legal and political drivers that create an enabling environment that supports or allows reproductive coercion.

For example, gender inequality, government policy and legislation, workplace practices, limited access to appropriate healthcare and enabling cultural and social norms.⁴⁶⁶

- 6.12 We now turn to explore forced sterilisation, followed by forced contraception and menstrual suppression.

Sterilisation

- 6.13 Sterilisation includes a range of surgical procedures that have a permanent impact on ceasing menstruation and fertility:

Sterilisation is a surgical operation or any other process that induces the permanent loss of reproductive capacity. For women, the most common and effective procedures are the hysterectomy, bilateral oophorectomy, tubal ligation and endometrial ablation. The most common procedure for girls with disability is the hysterectomy – removing the uterus and ceasing menstruation, yet continuing ovulation. Both bilateral oophorectomy and tubal ligation may be used in conjunction with a hysterectomy. A bilateral oophorectomy removes both ovaries. For a young woman with functioning ovaries this is a particularly serious operation, as it will cause a sudden termination of hormone production and commence menopause. She will need to undertake long-term hormone replacement therapy. Tubal ligation – blocking the female egg from proceeding down the fallopian tube - is less common as ovulation and menstruation will continue. A total hysterectomy may also be utilised, removing the uterus, ovaries, fallopian tube, cervix and upper vagina.⁴⁶⁷

- 6.14 There are numerous impacts of sterilisation on women and girls with disability, as noted by WWDA:

Forced sterilisation permanently robs women of their reproductive capacity, violates their physical integrity and bodily autonomy, and leads to profound and long-term

*physical and psychological effects, including: psychological pain, suffering, lifelong grief and trauma, extreme social isolation, family discord or breakdown, fear of medical professionals, social stigma, and shame.*⁴⁶⁸

- 6.15 However, the full range and extent of the impacts is not fully known due to a lack of research, as WWDA explains:

*The long-term consequences of forced and coerced sterilisation practices commonly used on women and girls with disability remain under-researched. There are very few research studies, including longitudinal studies that investigate the physical, psychological, sexual and other social impacts of these procedures for women and girls with disability.*⁴⁶⁹

- 6.16 One of the impacts of sterilisation is greater vulnerability to sexual violence. Removing the capacity for reproduction can mean a woman or girl can be sexually assaulted without any risk of detection through pregnancy.⁴⁷⁰

- 6.17 A second impact of sterilisation is lifelong trauma. Women and girls can be sterilised without their knowledge, only to discover at a later time, such as when they are trying to conceive children or have other health issues. This can give rise to trauma of being denied choice and autonomy. Women and girls who have been sterilised can also experience trauma from not being able to conceive children, form families and become parents. Third, a further, related impact is social exclusion. Women and girls who have been sterilised are excluded from key reproductive and sexual aspects of being human. Sterilisation thus dehumanises women and girls with disability through distancing them from the experiences and affective states that are associated with being human. WWDA explains these two kinds of impacts:

Forced sterilisation permanently robs women of their reproductive capacity, violates their physical integrity and bodily autonomy, and leads to profound and long-term physical and psychological effects, including: psychological pain, suffering, lifelong grief and trauma, extreme social isolation, family discord or breakdown, fear of medical professionals, social stigma, and shame.

Women with disabilities have spoken about forced sterilisation as a life sentence, as loss and betrayal, and of the health effects they can anticipate:

“I was devastated when my doctor advised me that the previous surgeon had done more than tie my tubes. He had actually removed parts of my reproductive system that could never be replaced.....I was shocked and furious.”

“Because I have had important parts of my body taken away it is hard to find out what is really going on in my body.”

“We have the right to control what happens to our own bodies.”

“Because I will not go through obvious menopause, in my culture that means I have no marker for becoming an ‘elder’.”

“Surgery of a healthy body is mutilation.”

“I am...taking a big risk on behalf of myself and my family in speaking up. I would like to know what is being done for us who have had this done twenty or thirty years ago? I don't have an intellectual disability and it was done before I started having a period. What research is being done to help us who were young children that went through this, and when we go through menopause? It can affect our health in the future. I think of this as my real disability – the physical one that you see isn't real – the one I had

happen to me when I was 12 is the main one and I don't have anyone to turn to."

"It has resulted in loss of my identity as a woman, as a sexual being."

"I have been denied the same joys and aspirations as other women."

"It stops us from having children if we want to."

"I worry about the future health effects like osteoporosis and other problems."

"The fact that services are not there is no reason for sterilisation."

"Sterilisation takes my choice away."

"I'm angry."

"I want to experience a period."

"Sterilization is a terrible thing to do to a woman. They had no right to do that to me. They never ask you about it. They told me that it was just for my appendix and then they did that to me."

"If they'd told the truth and asked me, I would have shouted 'No!' My sterilisation makes me feel I'm less of a woman when I have sex because I'm not normal down there.....When I see other mums holding their babies, I look away and cry because I won't ever know that happiness."

"Sterilisation takes away your womanhood."

"I do want to have children but I can't now."

"I got sterilised at 18, my mum said I had to – she said that if I ever had a child, she'd probably have to help look after it. She said: "I went through hell bringing you up and I will not do it again". It's more than 30 years now since I was sterilised and the pain is still unspeakable. It is the biggest regret of my life."

"For me it has meant a denial of my womanhood."

"I was sterilised and I wasn't ever told when I was getting it done. The specialist told mum about it but I didn't know I'd had it done until I was 18."

"I have always had a fear of speaking out about it – it's been very isolating."

"I want to help others who don't have a voice, to stop it happening to them – I feel powerless to do that."

"I will have no way of knowing about the onset of my menopause."

"I know it has resulted in hormone changes in my body that wouldn't have happened otherwise."

"It can lead to the break-up of relationships."

"I was what I call, 'socially sterilised' – I had the operation when I was a young woman because growing up I had been brainwashed to believe that disabled women like me can't be mothers. I would have loved to be a mother. There are of course, no proper words to describe the loss, the guilt, the regret and the pain I feel every day."

"Other people don't understand what it means in your life and it's very hard to explain that to people."

“Other women don’t understand what its like for us – it sets us apart from them.”

“For me it is about living with loss.”

“It really affects my self esteem.”

“It has stopped me having a normal life.”

“Its about loss of control.”

“For me it has meant a loss of trust – especially of doctors – those who women with disabilities often have to place their trust.”

“I have a blockage of emotions.”

“It’s a great emotional upheaval.”

“I feel alone and isolated.”

“The pain is hard to bear.”

“I have a fear of not being seen as a sexual identity – of sexual rejection.”

“I have feelings of rejection.”

“There is no information available for us.”

“There are not enough services or people to listen”.⁴⁷¹

6.18 Fourth, it is also thought that sterilisation is associated with higher incidence of gynaecological and hormonal conditions,⁴⁷² such as osteoporosis,⁴⁷³ and early menopause,⁴⁷⁴ and potentially also depression.⁴⁷⁵ These impacts of sterilisation, including social exclusion, trauma and gynaecological and hormonal conditions shows how a singular surgical procedure can have ongoing, lifelong impacts on women with disability, and deplete their quality of life and even reduce their life expectancy. Beyond the violence of the procedure itself, sterilisation can additionally be understood as a form of slow violence.

6.19 To reiterate the analysis in Section 4, forced sterilisation constitutes a grave violation of human rights, as explained by WWDA:

Forced sterilisation – that is, sterilisation in the absence of the free and informed consent of the individual concerned - including instances in which sterilisation has been authorised by a third party, without that individual’s consent - is an act of violence, a form of social control, and a clear and documented violation of the right to be free from torture. Forced sterilisation of girls and women with disabilities is internationally recognised as a harmful practice based on tradition, culture, religion or superstition. Perpetrators are seldom held accountable and women and girls with disabilities who have experienced this violent abuse of their rights are rarely, if ever, able to obtain justice. Successive Australian Governments have not acknowledged this pervasive practice, nor expressed regret, nor offered redress to the women and girls affected.

Forced sterilisation constitutes torture. The right to be free from torture is one of the few absolute and non-derogable human rights, a matter of jus cogens, a peremptory norm of customary international law, and as such is binding on all States, irrespective of whether they have ratified specific treaties. A State cannot justify its non-compliance with the absolute prohibition of torture, under any circumstances.⁴⁷⁶

As the late Elizabeth Hastings, Discrimination Commissioner of the then Human Rights and Equal Opportunity Commission (HREOC) stated in a keynote speech she delivered in 1998:

“A world in which government cannot be bothered to investigate potential illegal medical assault on nearly 200 of its citizens, in which those with no authority feel free to make decisions which are blatantly against the law and to carry out serious and irreversible procedures on those with little or no capacity to give or withhold consent, is a world in which people with disabilities can have no certainty or confidence about their human being or their future...”⁴⁷⁷

- 6.20 While the focus of the discussion on sterilisation is on forced and coercive sterilisation (i.e., procedures that are unwanted by women and girls with disability), many women with disability such as those with endometriosis or adenomyosis request endometrial ablation and want to consent to this procedure but health professionals deny them this opportunity to receive this care. Research on chronic pelvic pain experienced by women more broadly documents the challenges women encounter in having their pain recognised by health professionals, the invisibilisation of chronic pelvic pain, and the impact of gendered stereotypes about women as being hysterical or difficult on the failure of health professionals to provide the medical treatment women seek.⁴⁷⁸ The failure of health professionals to listen to and believe the experiences and needs of women in relation to endometrial ablation demonstrates the gendered ableism underpinning the role of the legal and health systems in sterilisation – we cannot simply assume that health or legal professionals are acting in the best interests of women and girls with disability by reason of their professional status and role.
- 6.21 These issues around healthcare professionals disregarding women with disability’s attempts to access and consent to surgery related to chronic pelvic pain might be particularly pronounced in relation to women with intellectual disability. These women might be considered incapable of consenting, with healthcare or social care professionals involved in the woman’s life seeking an order from a guardianship tribunal in lieu of the woman’s own consent. For example in the decision of the Guardianship Division of the NSW Civil and Administrative Tribunal,⁴⁷⁹ UMG (a woman described as having learning disability) sought a hysterectomy in response to chronic pelvic pain related to endometriosis. Her obstetrician applied for the Tribunal’s consent because they were unsure of UMG’s capacity to provide her own consent. The Tribunal ultimately decided she did have sufficient consent, however this was not until a tribunal hearing that explored in detail her disability, capacity and her reproductive health (including through multiple expert reports), well beyond what women without disability would ever be subjected to in accessing reproductive healthcare.

Historical Practices of Sterilisation

- 6.22 Sterilisation of women and girls with disability is a longstanding practice in twentieth century Australian history, and one which was done routinely in disability institutions.⁴⁸⁰ For example, at the 1990 STAR Conference on Sterilisation: *‘My Body, My Mind, My Choice’*, a woman with disability stated at the same conference that she was sterilised while living in a disability institution:

... after trying to have a baby for a long time I finally found out I had been sterilised when I was 14 living in an institution.⁴⁸¹

- 6.23 As reported by Goldhar in 1991, in an article published following the 1990 STAR Conference on Sterilisation:

“Sterilizations continued after the war. In Australia, as in other countries, sterilizations on women with an intellectual disability were rationalised on the basis that the operation was in their best interests. The woman would not have to be informed about menstruation. She would not have to experience the discomfort and inconvenience of monthly periods. There would be no danger of pregnancy with all its attendant pain and trauma; no need for abortions; no wasting time and energy on sex education.”⁴⁸²

- 6.24 In Australia the issue of sterilisation has been the subject of debate since the early 1980s when it became clear that many women with disability had been and were being sterilised without their consent and in some cases without their knowledge. It was clear this was happening with the informal consent of family, carers or doctors and without public scrutiny or accountability. This was in keeping with the legacy of the coercive and government sanctioned mass sterilisation of women with disability in pre-war Australia. Responses to these concerns at the time focused overwhelmingly on the legal issues involved in ‘authorising’ the procedure and not on the human rights of women and girls with disability. This focus has continued up until the present day and has resulted in the main thrust of public policy in the area being focused on reactive legislation to prevent further abuse and piecemeal development of appropriate protocols and support services.⁴⁸³
- 6.25 In disability institutional settings, sterilisation was interconnected with normalised sexual assault of women and girls with disability.⁴⁸⁴ In their government-commissioned public history of Peat Island Residential Centre, a disability institution that was operated by the NSW State Government for 99 years until 2020, Ellmoos and Andersen observe that women were subject to sexual assault and sterilisation, which they discuss in reference to the reflections of former Peat Island nurse, Margaret Scholtz:

The first female patients were admitted on a respite in 1976. Female residents were admitted on a permanent basis in 1978. From a nursing point of view, they tended to be ‘more trouble than most of the men’ because they required more individual attention. They would also have an impact on the equilibrium of the hospital as recalled by Margaret Scholtz.

‘Oh yes some of the boys knew the difference, some of the others didn’t. You had to watch that... very carefully. Most of the girls, I don’t think any of the girls were willing. There used to be one girl that we used to have to watch because the boys would line up. It’s not as if she has one steady boyfriend or something’.

Female residents were placed on contraceptives or had their tubes tied to prevent pregnancies.⁴⁸⁵

- 6.26 These examples of historical practices of sterilisation of women and girls with disability in institutional settings signal the importance of the governments and service providers that operated these institutions reckoning with, accounting for and repairing the historical injustices associated with sterilisation, including through redress.

Illegal (Unauthorised) Sterilisation

- 6.27 WWDA understands that some women and girls with disability are, and have been, sterilised without legal authorisation.
- 6.28 For example, one woman with disability stated at the 1990 STAR Conference on Sterilisation: ‘My Body, My Mind, My Choice’ a woman with disability stated:

I went to hospital and instead of having my appendix out, I had a tubal ligation.⁴⁸⁶

6.29 As Goldhar stated in 1991:

It is highly likely that most of these sterilizations took place without the consent of the woman involved. As a psychiatric superintendent of a large institution for people with an intellectual disability wrote nearly ten years ago: "Surgical procedures are frequently performed on retarded adults without their informed consent. The consent form is signed by the "next of kin" (not necessarily a parent), and in the case of a resident in a gazetted Training Centre, by the Superintendent....."⁴⁸⁷

6.30 There have been suggestions that doctors will do these procedures on the request of parents while a girl is undergoing other surgical treatment.

Suzie was sterilised at 6 years of age. A doctor performed a full hysterectomy on Suzie at the request of her parents because she was "almost blind". In later years, Suzie and her husband – both with full time professional careers – sought to adopt a child. Their applications were denied on the grounds of Suzie's vision impairment. They fought the decision which took them several years, but by the time they had the decision over-turned, they no longer met the age requirements for adoption. Their only remaining option was to seek a surrogacy arrangement, but they were advised that this would cost them upwards of \$300,000.⁴⁸⁸

A couple had their 15 year old disabled daughter 'secretly sterilised in hospital'. The doctor booked the young girl into the hospital in the mother's name. The mother explained:

"no one questioned me. No one, none of the nurses, no one. We were in a private room, we were on our own, and I stayed with her and then I brought her home and nursed her and she was fine..... It's something we have to do behind closed doors because people don't understand."⁴⁸⁹

6.31 A 1992 report from the Law Reform Commission of Western Australia, on 'Consent to Sterilisation of Minors' stated that:

"the reason why sterilizations have continued is simple. Hysterectomies, tubal ligations and, to a much lesser extent, vasectomies, have been used as an alternative to education and independence training by parents unable to come to terms with their children's sexuality."

6.32 A similar point was made in the context of the hearings of the 2013 Senate Community Affairs References Committee inquiry into Involuntary or coerced sterilisation of people with disabilities in Australia:

Donna: But there are also going to be people with intellectual disabilities who have no verbal capacity, and a lot of parents are making decisions to get their daughters done because then they do not have the issue of the pads and things like that. They would say that their daughter is not capable of looking after her own body so it is better to take her to the doctor to be fixed.

Senator Boyce: But you do have to go to the family court or tribunal to get their approval.

Donna: But I am talking about the earlier days, when you did not have to go to family courts; you just went to your GP and they referred you to a gynaecologist, and the gynaecologist said 'Yes, we'll do it, but you can't do it in the public hospitals, so we'll send you to a private hospital' —where it is all hush-hush, under the counter.⁴⁹⁰

One woman with disability stated in her evidence to the 2013 Sterilisation Senate inquiry that she had been pressured by her father into having a sterilisation, including because of

the risk they would pass on their disability to their child:

[Woman A] I wanted to have children and mix with other mothers who have children. I wanted to have children who would be friends with other people's children. The good thing is when you are a mother you get to mix with the other mothers and their children...

[support worker]...you were told that you should not have children. Is that right?

[Woman A] Yes I was told. My father said to me that my disability would pass on to my child and it would be more handicapped than me...

[support worker] You had conversations with your father where he said you should not have children. Then he said 'I want to get you sterilised'. Is that right?

[Woman A] Yes

...

[support worker] You had your relationship with [a boyfriend to whom she was engaged]. Did you want to have children with [your boyfriend?]

[Woman A] Yes..

Acting Chair: We would like to know what you want to say to us about [sterilisation] and about how it has impacted on you.

[Woman C]: My father did that.

Acting Chair: What happened? Did your dad say that you should not have children?

[Woman C] He said that people with a disability should not have kids.

Acting Chair: How did you feel about that?

[Woman C] Upset.

Acting Chair: What happened?

[Woman C] He told me I was going into hospital to have my tonsils out.

Acting Chair: That was not what happened?

[Woman C] I did not have a sore throat afterwards.

...

Acting Chair: When did you find out what happened?

[Woman C] After, when I was trying to have kids.

...

Acting Chair: Did you have a long-term partner?

[Woman C] Yes

Acting Chair: How did he feel?

[Woman C] He left me because he wanted to have kids and I could not have kids.

...

Acting Chair: In terms of how you feel now, what do you think should have happened?

[Woman C] I should have been told the truth. They should have told me.

Acting Chair: Did you try to have babies?

[Woman D]: I wanted to have babies.

Acting Chair: Did you think you were going to have babies?

[Woman D]: No. I had two operations.

...

Acting Chair: Do you know what the operations were for?

[Woman D]: To stop me having children.

Acting Chair: What did people tell you? Who did you talk with about having those operations?

[Woman D]: My parents.

Acting Chair: What did they say?

[Woman D]: You have to have the operation and that is it.

Mr Bowden [advocate]: Did you have a say?

[Woman D]: They forced me.

Senator Boyce: Did you say 'No, I don't want to?'

Woman D]: Yes.⁴⁹¹

- 6.33 Moreover, some parents seek to avoid the Australian legal framework by taking their daughter overseas.

A couple had their 15 year old disabled daughter sterilised in the United States. The parents wanted their daughter sterilised for menstrual management purposes and also to prevent a possible pregnancy in the future. The mother was of the view that, for her daughter to be sterilised in Australia would have been 'virtually impossible' and 'we'd have to break the law'. She explained:

'I've got many friends that have been down the line and been knocked back, some friends going through the process at the moment, some friends that it will come up in the next couple of years. The motivation for a parent to get an illegal sterilisation would be they're doing the best for their child. Health and hygiene would be the utmost. And they would be desperate. And, yeah, I'd go down that track if we were not able to get a hysterectomy for Laura in the States.'⁴⁹²

- 6.34 While there are laws prohibiting international travel for these purposes, they are not as strict as those pertaining to international travel for other gendered medical procedures such as female genital cutting.

- 6.35 On Monday 16 June, 2003 Four Corners (ABC TV) broadcast a program entitled "Walk in Our Shoes". The Program explored the issue of whether, and in what circumstances, women (and men) with disability should be sterilised.

- 6.36 The program highlighted cases of illegal sterilisation of girls (and young women) with disability, including one example of Trish who was 15 years old when she had the operation:

Sister: "The doctor booked Trish into hospital under my mother's name and I know

this would have created a lot of stress and tension for my parents at the time.”

Reporter: “So, to the outside world, it was you having the hysterectomy?”

Mother: “Yes. *But no one questioned me. No one, none of the nurses, no one. We were in a private room, we were on our own, and I stayed with her and then I brought her home and nursed her and she...she was fine.*”

Reporter: “*Although the law has swung behind the disability lobby, Four Corners has made contact with families who have had their daughters sterilised illegally. They would not come on camera for fear of prosecution.*”⁴⁹³

- 6.37 Some women with disability might consent to sterilisation in the context of no alternative options because of lack access to support and resources to enable them to menstruate. For example, one woman with disability explained that ‘while at home with her family’s assistance she had been using pads and tampons, but once living independently, the situation changed’:

So that I could self-toilet, or go to the toilet by myself, I stopped wearing underwear. This meant that pads were no longer an option. When I approached the service - a large service - that was supporting me, about tampons, I was told in no uncertain manner that tampons were not an option, that support workers could not insert or change tampons. So I really had no choice in the matter, I tried taking the pill for 90 days at a time and then having a short break to bleed...

I also tried Depo-Provera, but that made me gain weight. It was just not nice; it made me angry and grumpy, and there was still breakthrough bleeding...

*Eventually I made the choice, given those circumstances, of having no other choice and not being able to use tampons like every other woman, to have endometrial ablation and have my tubes tied.*⁴⁹⁴

- 6.38 In contrast to some of these stories of parents arranging forced or coercive sterilisation of their daughters with disability, one mother of a girl with disability stated in evidence to the 2013 Senate Sterilisation Inquiry that her daughter’s menstruation was a cause for celebration:

*...I have come across many women with daughters who have similar disabilities to my own daughter’s. When they found out that Amelia had started her period, their initial response to me was, ‘What are you going to do about it?’ To me, that was not an issue. It was just something we took in our stride. But there is this automatic response of, ‘We’ve got to solve this problem.’ This is another sense of abjection that we as a family are being exposed to... But my message today goes a little bit beyond human rights, I believe, to talk about celebration of the coming into womanhood of our daughters with disability. I think this is seriously lacking in the debate - a sense that, when our daughters with disability begin menstruating, it is a cause for celebration, as it is with their sisters. There may be difficulties that are incurred, but these are to be got over, along with their siblings. Most mothers of girls with intellectual disabilities, I believe, share my position.*⁴⁹⁵

- 6.39 We now turn to explore legally authorised forced sterilisation.

Legal Authorisation of Sterilisation

- 6.40 Forced and coercive sterilisation (as well as contraception and menstrual suppression, which we discuss further below) can be lawful, if authorised through one of a variety of legal frameworks, such as:

- Common law *parens patriae* doctrine that grants State and Territory Supreme

Courts jurisdiction to order sterilisation;⁴⁹⁶

- Guardianship laws that authorise specified tribunals to order sterilisation and appointment of substitute decision-makers to authorise contraception and menstrual suppression as restrictive practices;⁴⁹⁷
- Mental health laws which in some states and territories authorise specified tribunals to order sterilisation and authorise medical officers to decide on contraception and menstrual suppression;⁴⁹⁸
- Family Court's welfare jurisdiction which authorises parents to consent to sterilisation of their disabled children;⁴⁹⁹ and
- Child protection legislation which in some states and territories authorises specified courts to order sterilisation.⁵⁰⁰

6.41 As discussed in Section 2, there is limited available quantitative data on forced and coercive sterilisation, contraception and menstrual suppression in Australia and the lack of official data collection of these practices remains an ongoing issue. Based on annual 'Australian Sterilisation Data Reports'⁵⁰¹ reporting on data provided by State and Territory Tribunals between June 2016-June 2020, show that 31 applications for sterilisation of adults with cognitive impairment were approved. Based on data provided to the Senate Committee and reported in its 2013 sterilisation report: the Family Court of Australia heard 27 cases for applications to perform hysterectomies on young people with disability. Only two of these were heard since 2000, the rest in the 1990s.⁵⁰² The state and territory administrative tribunals considered matters as per the table from the 2013 Senate sterilisation report,⁵⁰³ some of which related to males:

Jurisdiction	Time period	Applications	Withdrawn	Approved	Dismissed	Applications per unit population ¹⁵
ACT	21 years	13	1	12	0	1.55
NSW	6 years	38	8	14	17	0.87
NT	10 years	3	0	3	0	1.50
QLD	6 years	21	5	14	2	0.76
SA	7 years	12	NK	10	NK	1.01
TAS	10 years	c. 10	c. 5	c. 3	c. 1	2.00
VIC	6.5 years	102	NK	NK	NK	2.75
WA	10 years	5	0	3	2	0.20

Notes: NK = Not known. Rates calculated using ABS 2012 state and territory population estimates. Victorian sample commences after the exclusion from tribunal jurisdiction of applications for medical research.

- 6.42 A recent search of Australian Legal Information Institute (Austlii) and Australian legal case citation databases identified the following decisions on authorisation of forced sterilisation:

Sterilisation matters involving women and girls with disability			
	Decision	Procedure	Outcome
NSW	<i>JZL</i> [2021] NSWCATGD 13	Sterilisation (Laparotomy with bilateral salpingo-oophorectomy and hysterectomy)	Application approved
	<i>MCF</i> [2020] NSWCATGD 77	Sterilisation (Abdominal hysterectomy and bilateral salpingo-oophorectomy)	Application approved
	<i>TZV</i> [2020] NSWCATGD 76	Sterilisation (External beam radiotherapy to pelvis and para aortic lymph nodes)	Application approved
	<i>Re OBD</i> [2016] NSWCATGD 58	Sterilisation (Endometrial ablation)	Application dismissed (applicant can consent without tribunal approval)
	<i>Re QMI</i> [2016] NSWCATGD 59	Sterilisation (Hysterectomy)	Application approved
	<i>Re NKI</i> [2015] NSWCATGD 59	Sterilisation (Abdominal hysterectomy and bilateral salpingectomy)	Application approved
	<i>Re UMG</i> [2015] NSWCATGD 54	Sterilisation (Hysterectomy)	Application dismissed (applicant can consent without tribunal approval)
	<i>Re UBE</i> [2015] NSWCATGD 57	Sterilisation (Laparoscopic tubal ligation)	Application dismissed (applicant can consent without tribunal approval)
	<i>Re UFH</i> [2015] NSWCATGD 58	Sterilisation (Laparoscopic hysterectomy and bilateral salpingectomy)	Application dismissed (applicant can consent without tribunal approval)
	<i>Re MMW</i> [2014] NSWCATGD 34	Sterilisation (hysterectomy with ovarian conservation)	Application dismissed (applicant can consent without tribunal approval)
	<i>Re NXM</i> [2014] NSWCATGD 52	Sterilisation (Hysterectomy)	Application dismissed (not necessary to save patient's life or prevent serious damage to patient's health)
	<i>Re NXM (No 2)</i> [2014] NSWCATGD 53	Sterilisation (Hysterectomy)	Application approved
	<i>PYR</i> [2012] NSWGT 30	Sterilisation (Endometrial ablation)	Application dismissed (need to consider less invasive treatment options)
	<i>LDS</i> [2012] NSWGT 9	Sterilisation (Hysterectomy)	Application approved
	<i>Re XTV</i> [2012] NSWGT 5	Sterilisation (endometrial ablation)	Application dismissed (not necessary to save patient's life or prevent serious damage to patient's health)
	<i>TAC</i> [2010] NSWGT 23	Sterilisation (Hysterectomy)	Application dismissed (applicant can consent without tribunal approval)
<i>WAK</i> [2010] NSWGT 25	Sterilisation (Hysterectomy with bilateral salpingo-oophorectomy - with Postoperative radiation treatment if required)	Application approved	
<i>MNY</i> [1996] NSWGT 1	Sterilisation (Hysterectomy)	Application approved	

QLD	<i>In an application about matters concerning CM</i> [2022] QCAT 263	Sterilisation (Laparoscopic hysterectomy with bilateral salpingectomy and laparotomy)	Application approved
	<i>EKF</i> [2017] QCAT 434	Sterilisation (Hysterectomy)	Application approved
	<i>CEN</i> [2012] QCAT 387	Sterilisation (Tubal ligation)	Application approved
	<i>CN</i> [2012] QCAT 11	Sterilisation	No decision finalised (insufficient information available to make decision)
	<i>TN</i> [2012] QCAT 713	Sterilisation (Hysterectomy)	Application approved
	<i>HGL (No 2)</i> [2011] QCATA 259	Sterilisation	Application approved
	<i>Re AAE</i> [2007] QGAAT 59	Sterilisation (Hysterectomy)	Application approved
	<i>Re CMH</i> [2004] QGAAT 7	Sterilisation (Hysterectomy)	Application approved
	<i>Re AX</i> [2000] QGAAT 4	Sterilisation (Hysterectomy)	Application approved
TAS	<i>UI (Consent to Special Medical Treatment)</i> [2020] TASGAB 48	Sterilisation (Tubal ligation)	Application approved
	<i>MZS (Consent to Special Medical Treatment)</i> [2019] TASGAB 40	Sterilisation (Laparoscopic total hysterectomy and salpingectomy)	Application approved for laparoscopic total hysterectomy and salpingectomy, but not oophorectomy
	<i>QN (Medical Consent)</i> [2018] TASGAB 13	Sterilisation (Salpingectomy)	Application approved
	<i>KI (Medical Consent)</i> [2018] TASGAB 12	Sterilisation (Laparoscopy with ligation of fallopian tubes with fischie clips or removal of fallopian tubes)	Application dismissed (not the necessary and the least restrictive way to achieve the purpose of preventing pregnancy)
	<i>MG (Medical Consent)</i> [2004] TASGAB 5	Sterilisation (Hysterectomy)	Application dismissed (not in a position to say that no other less restrictive treatment will work as other option untested)
VIC	<i>ZEH (Guardianship)</i> [2015] VCAT 2051	Sterilisation (Tubal ligation)	Application dismissed (no compelling justification for the special procedure and not the least restrictive option)
	<i>SBM (Guardianship)</i> [2014] VCAT 1654	Sterilisation (Tubal ligation)	Application dismissed (applicant can consent without tribunal approval)
WA	<i>EW</i> [2021] WASAT 111	Sterilisation (Tubal ligation)	Application approved
	<i>JS v CS</i> (2009) 63 SR (WA) 23	Sterilisation (Hysterectomy)	Application dismissed (applicant can consent without tribunal approval)
	<i>AD</i> [2007] WASAT 123	Sterilisation (Hysterectomy)	Application dismissed (no compelling justification for procedure)
	<i>Re P</i> (1993) 12 SR (WA) 255	Sterilisation	Application dismissed
	<i>Re S</i> (1993) 12 SR (WA) 258	Sterilisation	Application dismissed (Public Guardian appointed for purpose of administering contraception and develop self-help skills)
	<i>Re D</i> (1998) 24 SR (WA) 163	Sterilisation	Application approved

CTH	Family Court:		
	<i>Re Katey</i> [2018] FAMCA 916	Sterilisation (Laparoscopic hysterectomy with ovarian preservation)	Application allowed
	<i>Re Edith</i> [2014] FAMCA 908	Sterilisation (Laparoscopic partial hysterectomy)	Application allowed
	<i>Re Angela</i> (2010) 43 Fam LR 98	Sterilisation (Hysterectomy)	Application allowed
	<i>Re BW</i> (unreported, FamCA, Chisholm J, 10 April 1995)		unpublished
	<i>Re W</i> 10/04/1995 FamCt Unreported		unpublished
	<i>Re Katie</i> (1995) 128 FLR 194	Sterilisation	Application allowed
	<i>P & P</i> (1995) 126 FLR 245	Sterilisation (Hysterectomy)	Application allowed
	<i>L & G M v M M</i> (1993) 17 Fam LR 357	Sterilisation (Hysterectomy)	Application dismissed
	<i>Re M (an infant)</i> (1992) 106 FLR 433	Sterilisation (Hysterectomy)	Application dismissed (procedure authorised under NSW legislation instead)
	<i>In re Marion</i> (1990) 14 Fam LR 427; <i>In re Marion (No 2)</i> (1992) 17 Fam LR 336	Sterilisation (Hysterectomy)	Application allowed
	<i>In Re Elizabeth</i> (1989) 13 Fam LR 47	Sterilisation (Hysterectomy)	Application allowed
	<i>Attorney-General (Qld) v Parents; In re S</i> (1989) 98 FLR 41	Sterilisation (Hysterectomy)	Application allowed
	<i>Re Jane</i> (1988) 85 ALR 409	Sterilisation (Hysterectomy)	Application allowed
	<i>In Re a Teenager</i> (1988) 13 Fam LR 85	Sterilisation (Hysterectomy)	Application dismissed (parents have authority to consent without court authorisation)
	High Court:		
	<i>P v P</i> (1994) 181 CLR 583	Sterilisation	Considering legal issues, not sterilisation application itself
	<i>Dept of Health and Community Services (NT) v JWB and SMB (Marion's case)</i> (1992) 175 CLR 218	Sterilisation	Considering legal issues, not sterilisation application itself

6.43 When comparing the numbers of sterilisation decisions in the Australian Sterilisation Data Reports with the case citator databases it is apparent that the case citator databases are not comprehensive. Courts and tribunals do not publish all of their decisions relating to sterilisation, because the principle of open justice (which provides for public access to the hearings and decisions of courts) does not apply to court decisions related to the common law doctrine of *parens patriae*, and a similar position applies in relation to guardianship and mental health tribunals. The lack of transparency in relation to judicial and tribunal decision-making on sterilisation is a significant issue of concern that undermines equal access to justice for women and girls with disability and prevents a comprehensive understanding of the role of legal and justice systems

in perpetration of sexual and reproductive violence against women and girls with disability.⁵⁰⁴

- 6.44 While the decisions listed in the table above do not constitute every decision made by the courts and tribunals and nor are they a representative sample, it is interesting to note that in relation to the state and territory guardianship tribunal decisions in relation to women with disability, 8 of the 17 applications which were dismissed were dismissed on the basis that the woman had capacity to make her own decision about the procedure and in some of these decisions it was the woman herself who was seeking the procedure. While the discussion below focuses on legal authorisation of forced sterilisation, these decisions where sterilisation has *not* been authorised on the basis of a woman's capacity highlights the problematic denial of reproductive autonomy to women with disability by reason of assumptions made by healthcare and social care professionals. This observation confirms the earlier concern we raised about women with disability being denied autonomy to make their own decisions about reproductive healthcare for endometriosis and chronic pelvic pain.
- 6.45 We now turn to discuss the overarching legal framing of forced sterilisation through the common law doctrine of *parens patriae*, then turn to explore authorisation under family law and guardianship law.

Common Law Doctrine of Parens Patriae

- 6.46 '*Parens patriae*' is a Latin term meaning 'the parent of his or her country'. Pursuant to the common law doctrine 'the Sovereign has an obligation to protect the interests of those unable to protect themselves, such as protecting the assets of children and 'lunatics.'⁵⁰⁵ The *parens patriae* jurisdiction has been described by Sackar J in a NSW Supreme Court case on legal authorisation of forced abortion:

It is appropriate that I observe that the parens patriae jurisdiction is ancient, wide-ranging and far-reaching. It extends as far as necessary for the protection of children and those persons who from their legal disability cannot look after themselves and are in need of protection: Marion's Case (1992) 175 CLR 218, 258-9 (Mason CJ, Dawson, Toohey and Gaudron JJ) 278-80 (Brennan J). The jurisdiction requires and obliges the Court to act in the manner of a wise, affectionate and careful parent for the welfare of the person: R v Gyngall (1893) 2 QB 232 at 241 (Lord Esher MR); Marion's Case at 280 (Brennan J).

The jurisdiction's focus is essentially protective in nature. In exercising the jurisdiction the Court's concern is predominantly the welfare of the person involved: Re Frances and Benny [2005] NSWSC 1207 at [17] per Young CJ in Eq.

The jurisdiction is not encumbered with technicalities. No jurisdictional limits have been described and, subject to the requisite nexus to the child or incapable person, it is seemingly unlimited. The situations in which the jurisdictions can be invoked are myriad. Whilst broad, it is generally to be exercised only in exceptional cases and with considerable caution. In the case of an adult, this caution is especially important because care should always be taken to ensure that there is no interference unlawfully in the free will of a capable individual.⁵⁰⁶

- 6.47 Historically, the doctrine of *parens patriae* was applied by state and territory Supreme Courts. While state and territory Supreme Courts generally still retain this jurisdiction

(unless legislation explicitly excludes their jurisdiction), there are now also specialised courts and tribunals that also exercise this jurisdiction, including those administering mental health, guardianship and child welfare law.⁵⁰⁷

- 6.48 The common law doctrine of *parens patriae* shows how forced sterilisation and abortion are not merely forms of legal violence but more specifically, are forms of gendered ableist violence. This can be understood by reference to judicial discussion of the exclusion of the principle of open justice from courts where they are applying the common law doctrine of *parens patriae*. French CJ in *Hogan v Hinch* stated:

*The jurisdiction of courts in relation to wards of the State and mentally ill people was historically an exception to the general rule that proceedings should be held in public because the jurisdiction exercised in such cases was “parental and administrative, and the disposal of controverted questions ... an incident only in the jurisdiction”.*⁵⁰⁸

- 6.49 Chief Justice French cited the decision of *Scott v Scott*. In *Scott v Scott*, Viscount Haldane LC explained why the court’s work in relation to the common law doctrine of *parens patriae* is distinct to the general practice of open courts:

The case of wards of Court and lunatics stands on a different footing. There the judge who is administering their affairs, in the exercise of what has been called a paternal jurisdiction delegated to him from the Crown through the Lord Chancellor, is not sitting merely to decide a contested question. His position as an administrator as well as judge may require the application of another and overriding principle to regulate his procedure in the interest of those whose affairs are in his charge.

*... While the broad principle is that the Courts of this country must, as between parties, administer justice in public, this principle is subject to apparent exceptions, such as those to which I have referred. But the exceptions are themselves the outcome of a yet more fundamental principle that the chief object of Courts of justice must be to secure that justice is done. In the two cases of wards of Court and of lunatics the Court is really sitting primarily to guard the interests of the ward or the lunatic. Its jurisdiction is in this respect parental and administrative, and the disposal of controverted questions is an incident only in the jurisdiction. It may often be necessary, in order to attain its primary object, that the Court should exclude the public. The broad principle which ordinarily governs it therefore yields to the paramount duty, which is the care of the ward or the lunatic.*⁵⁰⁹

- 6.50 In a similar vein, Lord Shaw of Dunfermline in *Scott v Scott* stated in relation to ‘suits affecting wards’ and ‘lunacy proceedings’:

*these cases, my Lords, depend upon the familiar principle that the jurisdiction over wards and lunatics is exercised by the judges as representing His Majesty as *parens patriae*. The affairs are truly private affairs; the transactions are transactions truly *intra familiam*; and it has long been recognized that an appeal for the protection of the Court in the case of such persons does not involve the consequence of placing in the light of publicity their truly domestic affairs.*⁵¹⁰

- 6.51 Also in *Scott v Scott*, Earl of Halsbury stated:

*There are three different exceptions commonly so called, though in my judgment two of them are no exceptions at all. The first is wardship and the relation between guardian and ward, and the second is the care and treatment of lunatics. My Lords, neither of these, for a reason that hardly requires to be stated, forms part of the public administration of justice at all.*⁵¹¹

- 6.52 This judicial commentary highlights that the common law doctrine of *parens patriae*

positions the court as inherently benevolent and as coming to the rescue of helpless and vulnerable people with disability in order to protect them from threats to their safety and wellbeing external to the justice system. When courts exercise the jurisdiction provided by the common law doctrine of *parens patriae* the very nature and purpose of the court shifts, from being situated in the public sphere and exercising justice as an arm of the state for the benefit of the broader public, to being situated in the private sphere and playing the role of the protective father to a child. There are *three* specific ways in which the common law *parens patriae* doctrine demonstrate the gendered ableist legal violence of legally authorised forced sterilisation and abortion.

- 6.53 First, the common law doctrine of *parens patriae* is understood in highly gendered terms as modelled on the assumed familial, patriarchal authority of the father over the vulnerable child in the private sphere of the home.
- 6.54 Second, by reason of their assumed incapacity and vulnerability, people with disability are likened to children and for this reason are naturally assumed to submit to the familial, patriarchal protection of the father/judge. This construction of people with disability relies on a medicalised and ableist understanding of people with disability as inherently violable (by forces external to the justice system) and non-agential.
- 6.55 Third, the court's legal construction as the private family home and judge's construction as a father figure is premised on the assumption that within the home the father is automatically loving, kind and protective to his family. This assumption has been challenged by decades of feminist activism and feminist legal scholarship that has highlighted violence within the family home perpetrated by fathers and how the artificiality of the public/private divide serves to conceal violence within domesticated settings, protect male perpetrators from accountability, and exclude victims-survivors from redress and justice systems. This legal construction of the judge justifies their role in regulating forced sterilisation as a benevolent and protective and ultimately non-violent act, and constructs the court itself as a space of safety and non-violence (i.e., that violence happens somewhere 'out there', but not in the courtroom). The common law doctrine of *parens patriae* is legal patriarchy writ large.
- 6.56 The combination of the legal construction of people with disability as vulnerable children, the judge as protective father and court as the non-violent and protective home establishes the distinctiveness of the court's exercise of this jurisdiction as opposed to other jurisdictions, and thus justifies the absence of public scrutiny of courts applying the common law doctrine of *parens patriae* (as per the open justice principle). This distinctiveness justifies the lack of public transparency and accountability for the courts' role in authorising the violence of forced sterilisation and abortion (as evident in the limited decisions and data on sterilisation, contraception and menstrual suppression decisions made by Australian courts and tribunals, discussed above).
- 6.57 The common law doctrine of *parens patriae* also gives rise to acute settler colonial violence when it applies to First Nations people with disability insofar as the key dynamics of the child, father and family home underpinning the gendered ableist legal violence positions First Nations peoples with disability as childlike, the judge as rescuer and protector of First Nations peoples and the court of the settler colonial white nation state as non-violent. For example, Mills and Lefrancois note that 'the child functions as a metaphor for colonized, racialized, psychiatrized and disabled peoples'⁵¹² and that 'metaphoric of child/colony is contingent on patriarchal domination, where the familial ruling of the husband/father is naturalized as a model for colonial domination'.⁵¹³

- 6.58 In exploring forced sterilisation and abortion, it is crucial that the Royal Commission consider the common law doctrine of *parens patriae* and fully interrogate its ableist, heteropatriarchalist and settler colonial dynamics. This is particularly important because the doctrine has an enduring existence beyond any legislative reforms to mental health or guardianship legislation. Even if mental health and guardianship legislation was completely abolished, the common law doctrine of *parens patriae* would continue to apply to people with disability unless explicitly excluded through legislation. Despite the significance of the common law doctrine of *parens patriae*, it is rarely discussed and scrutinised in government inquiries on sexual and reproductive violence, with the focus instead being on guardianship and mental health legislative frameworks. The failure of past government inquiries to interrogate the *parens patriae* jurisdiction and make recommendations to prevent its application to people with disability further depoliticises law's role in sexual and reproductive violence against women and girls with disability.
- 6.59 Guardianship law is presented as more progressive than the common law doctrine of *parens patriae* by reason of the informal tribunal procedure coupled with substantive criteria for decision-making which are said to be more focused on working towards empowering individuals. However, these innovations are mere window-dressing because guardianship law still reflects the gendered ableism of the common law doctrine of *parens patriae* by reason of its core purpose of facilitating substitute decision-making (as we explore in our submission to the Royal Commission on guardianship). This is exemplified by some states and territories still referring to guardians as having a role similar to a parent, thus reflecting the dynamic of parent and child. In Western Australia, a plenary guardian has the same functions as are vested in a person under the *Family Court Act 1997* in relation to a parenting order which allocates parental responsibility for a child 'as if the represented person were a child lacking in mature understanding'. However, the plenary guardian does not 'have the right to chastise or punish a represented person'.⁵¹⁴

Family Court Authorisation of Sterilisation

- 6.60 The Family Court is one of the primary jurisdictions for authorisation of sterilisation of girls with disability. As recently as 2018, the Family Court authorised parental consent to a forced sterilisation of a 17 year old girl with intellectual disability who was distressed by her periods.⁵¹⁵
- 6.61 In *Secretary, Department of Health and Community Services v JWB (Marion's Case)*⁵¹⁶ the High Court considered the role of the Family Court in authorising sterilisation of authority of children with disability. The court decided that where a child is capable of giving informed consent to the procedure, they can consent on their own behalf (although no child would ever be asked to give informed consent to sterilisation). The court decided that an individual is capable of giving informed consent when they achieve 'a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'.⁵¹⁷ In relation to children who lack mental capacity, the court decided that whether parental consent requires authorisation by the Family Court depends upon the purpose of the sterilisation – whether the sterilisation is therapeutic or non-therapeutic.⁵¹⁸
- If the sterilisation is 'therapeutic', that is, if it is a 'by-product of surgery appropriately carried out to treat some malfunction or disease',⁵¹⁹ then the parents have the authority to consent on the child's behalf to the sterilisation without seeking court authorisation.⁵²⁰
 - If the sterilisation is 'non-therapeutic', that is, other than a by-product of surgery for malfunction or disease, then sterilisation falls outside of the scope of

parental authority and consequently the Family Court, pursuant to s 67ZC of the *Family Law Act 1975* (Cth), must authorise the parental consent.⁵²¹

- 6.62 This division between therapeutic and non-therapeutic is also seen in the context of legal regulation of contraception and menstrual suppression as either medical treatment (therapeutic) or restrictive practices (non-therapeutic), as we discuss further below. What the High Court decided about the legal division between therapeutic and non-therapeutic sterilisation in the Family Court’s welfare jurisdiction, and the reduced legal scrutiny given to ‘therapeutic sterilisation’, might appear prima facie unproblematic on the assumption therapeutic sterilisation is directed towards medical need. However, justifying sterilisation on the basis of therapeutic necessity can be problematic because what is considered medically necessary for a girl with disability can be different to what would be considered necessary for a non-disabled child. This is not least of all because of the prevailing medical approach to disability (introduced in Section 5). The lack of judicial involvement in regulating therapeutic sterilisation means it is difficult to quantify this category of sterilisation (as compared to the incomplete data available on non-therapeutic sterilisation authorised by courts and tribunals).
- 6.63 The availability per se of non-therapeutic sterilisation is indicative of gendered ableism because it would be incomprehensible to sterilise non-disabled girls for reasons other than those related to serious and life-threatening medical issues.
- 6.64 The Family Court’s jurisdiction over non-therapeutic sterilisation is within the Commonwealth’s legislative power because sterilisation of a child of a marriage directly relates to the protection and welfare of the child. It thus arises out of, and is itself an aspect of, the relevant marriage relationship of the parents of that child and, moreover, directly concerns parental rights and the custody or guardianship of infants in relation to divorce or matrimonial causes. This reflects gendered ableism because it assumes girls with intellectual disability are eternal children – they are not considered cognitively capable and/or responsible enough to engage in reproductive labour involved in menstruation, reproduction, sexual activity and parenting, as explained by Steele:

The court only has jurisdiction over the girls in sterilisation cases because they are children, ie, its jurisdiction ceases once the girls turn 18 years of age. However, sterilisation is a procedure which effects — prevention of reproduction, limits on sexual pleasure, early onset of menopause, possible increased risk of cancer, loss of womanhood, and difficulty forming heterosexual relationships due to infertility — will be more apparent in adulthood, prompting the argument that sterilisation is ‘a question for adulthood, not childhood’. There consequently is a tension between the jurisdiction over the girl as a child and the relevance of sterilisation to the girl as an adult.

To address this adult issue in the context of childhood, in relation to teenage (rather than infant) girls, ‘makes sense’ only where intellectual disability is understood by reference to the medical model of disability. Pursuant to this model, the girls are understood as incapable of further mental development past childhood and as forever dependent on their parents in an infantile manner for care such that they effectively never reach adulthood (in the sense both of their age and their independence). The court’s focus is therefore not on ‘the young woman as a minor for the time being, but as a person who will always have the mind of a child’—an eternal child.⁵²²

- 6.65 This is reflected in the justifications used for court authorisation of sterilisation of disabled women and girls, where ‘incapacity’ has been considered to be a fixed state, with no consideration given to the possibility of capacity evolving over time:

“Those who are severely intellectually disabled remain so for the rest of their lives”.

“There is no prospect that she will ever show any improvement in her already severely retarded mental state.”

Katie would never be able to contribute to self-care during menstruation..... Katie is unable to understand re-production, contraception, pregnancy and birth and that inability is unlikely to change in the foreseeable future.

Sarah is unable to understand reproduction, contraception and birth and that inability is permanent.....her condition will not improve.

‘HGL is unlikely, in the foreseeable future, to have capacity for decisions about sterilisation.’

‘There has been no alteration in H’s capacity for eighteen months and it has been assessed that there will be no improvement in H in the future.’⁵²³

- 6.66 The Family Court’s jurisdiction of non-therapeutic sterilisation of girls with disability reflects an assumed temporal asynchronicity between their bodies and minds such that the violence of non-therapeutic sterilisation is necessary in order to bring the girls’ bodies into temporal alignment with their minds.⁵²⁴ While the Family Court’s jurisdiction over sterilisation is premised on girls never possibly developing into adulthood and womanhood,⁵²⁵ the perversity is that the sterilisation procedure itself has the material effect of removing some of the markers of adolescence and adulthood.
- 6.67 The Family Court’s jurisdiction over non-therapeutic sterilisation as related to the parent-child relationship is premised on the assumption that the circumstances giving rise to applications for sterilisation are the sole responsibility of parents. Consequently, if parents themselves do not have time or resources to address these circumstances, state authorisation (through the Family Court) of the violence of sterilisation is a legitimate response and the state remains unaccountable both for its failure to provide the necessary support and resources to avoid sterilisation *and* for authorising the sterilisation. Thus, the Family Court’s jurisdiction over non-therapeutic sterilisation ‘individualises and privatises the failure of the state to provide appropriate support’ and ‘and masks systemic policy failures that position sterilisation as the solution to care and well-being issues’.⁵²⁶ Its jurisdiction privatises the provision of care, support and safety to girls with disability, and renders violence justifiable for families to meet these needs.⁵²⁷
- 6.68 In relation to non-therapeutic sterilisation, parental consent must be authorised pursuant to s 67ZC of the *Family Law Act 1975* (Cth). This provides that the Family Court has ‘jurisdiction to make orders relating to the welfare of children’,⁵²⁸ and that in deciding whether to make such orders ‘a court must regard the best interests of the child as the paramount consideration’.⁵²⁹ In general, the ‘best interests’ test effaces the violence of authorising sterilisation by positioning judges, aided by lawyers, doctors and other professionals, in the role of acting benevolently to decide what will most benefit an individual. Yet, this overlooks the ableism embedded in health systems (as has been highlighted by the Royal Commission’s issues paper and hearings on healthcare),⁵³⁰ disability service systems (as has been highlighted by the Royal Commission’s issue papers and hearings on group homes) and legal and justice systems (concerningly an issue the Disability Royal Commission is yet to explore).
- 6.69 The ‘best interests of the child’ is explained as primarily related in s 60CC of the *Family Law Act 1975* (Cth) to the relationship between the child and parent/s: ‘the benefit to the child of having a meaningful relationship with both of the child’s parents’ and ‘the need to protect the child from physical or psychological harm from being subjected to, or exposed to, abuse, neglect or family violence’.⁵³¹ Additional considerations in determining best interests are similarly focused on factors pertaining to the relationship between the child

and parents.⁵³² It is apparent that these factors relate to parenting arrangements and have not been devised with non-therapeutic sterilisation in mind. Although, if some of those factors related to violence prevention are applied to non-therapeutic sterilisation, then it is arguable that non-therapeutic sterilisation should never be authorised pursuant to s 67ZC because it is a form of violence, as explained by Steele:

On the one hand, in the Family Court's welfare jurisdiction, sterilisation in the context of the parent–child relationship is said to be in the best interests of a child with disability yet, on the other hand, the welfare jurisdiction is supposed to protect children from family violence and abuse, and sterilisation is a form of violence. As such, the current jurisdictional framework results in a contradictory situation where the Family Court can authorise an act of family violence (in the form of sterilisation of a child with disability) pursuant to a test that has as part of its purported purpose the protection of children from family violence. The Family Court's 'supervisory' jurisdiction over parents vis-à-vis non-therapeutic sterilisation means it not only fails to protect children from family violence, but actually permits and legitimises a form of family violence that, by the contours of its very jurisdiction, it should in fact be protecting children from.⁵³³

- 6.70 The Family Court in *Re Marion (No 2)*⁵³⁴ outlined a number of relevant factors to consider in determining whether sterilisation would be in the best interests of a child. These factors are focused on the appropriateness of sterilisation viewed as a 'procedure or treatment', including the nature of and reasons for the treatment. The next consideration is that surgical sterilisation is a step of last resort; that is, 'alternative and less invasive procedures have all failed or that it is certain that no other procedure or treatment will work'. Once the Family Court is satisfied in regard to all of these factors, it can make an order pursuant to s 67ZC authorising parental consent to the sterilisation of a girl with disability. The effect of such an order is to enable the parents/guardians of the girl to give consent to the sterilisation procedure.⁵³⁵
- 6.71 The Family Court has determined that non-therapeutic sterilisation is in the best interests of a girl with disability for a variety of reasons associated with the menstrual, sexual, and care circumstances (actual or anticipated) of girls with disability. WWDA has previously identified five bases on which sterilisation is authorised on girls with disability.⁵³⁶
- **Genetic/eugenic argument:** The fear that disabled women will re/produce children with genetic 'defects'.
 - **For the good of the state, family or community:** The 'burden' that disabled women and girls and their potentially disabled children place on the resources and services funded by the state and provided through the community, and the added 'burden of care' that menstrual and contraceptive management places on families and carers.
 - **Incapacity for parenthood:** Disabled women cannot be effective parents.
 - **Incapacity to develop and evolve:** Incapacity in this context, is considered to be a fixed state, with no consideration given to the possibility of capacity evolving over time.
 - **Prevention of sexual abuse:** Protect disabled women and girls from sexual abuse and the consequences of abuse in a context where disabled girls are particularly vulnerable.

- 6.72 All of these reasons are underpinned by gendered ableism insofar as women and girls with disability are constructed as abnormal and incapable and a burden on their families because they are incapable of the reproductive labour of reproduction, menstruation, and parenting.⁵³⁷ In turn the reproductive aspects of their bodies lack utility and become irrelevant and disposable. This is particularly apparent in relation to how some of the Family Court decisions discuss menstruation, as Steele and Goldblatt summarise here:

During the 1980s and 1990s, there were a number of FCA decisions and Australian High Court decisions concerning sterilization of girls with disabilities. These decisions illustrate ... problematic associations between disability, gender, and menstruation ...

They portray girls as risky and dangerous by reason of their leaky bodies and irrational behaviour attributed to their menstruation (Steele 2008, 2016). The girls are portrayed as being unable to comprehend menstruation as part of their bodies' processes. For example, in one decision the judge stated: "[during menstruation] L threw herself on the floor and scratched herself on the legs and face, . . . she would lash out if someone tried to assist her so they might be injured and she would claw her own body with her fingers until she drew blood" (Re BW (unreported, FamCA, Chisholm J, 10 April 1995) at 10). In this context, sterilization is viewed by judges as being in the girls' best interests because it will protect them from their erratic and risky behaviour associated with menstruation and protect them from pregnancy and childbirth, including pregnancy arising from sexual abuse. Judges have also expressed need to use sterilization to avoid the "frightening and unnecessary experience" of being in public with visible bleeding (Re Jane (1988) 12 Fam LR 662 at 681). The judges also approach sterilization as being in the best interests of the child because it will protect parents and carers from the burden of care imposed by their superfluous menstruation and related behaviour, and the burden of caring for any child born (Steele 2008). For example, Warnick J described sterilization of Katie as "lessen[ing] the physical burdens for the mother, in particular by decreasing the number of changes necessary in toileting" (Re Katie (FamCA, Warnick J, 30 November 1995) at 15). Moreover, in some decisions, the Family Court rejected alternatives to menstrual management on the basis that they would not be successful. For example, in one decision Cook J dismissed a menstrual management education program because he considered it "difficult to avoid the feeling, that here, perhaps too much reliance is being placed on the success of what are possibly imperfect programs, imperfectly administered and monitored upon, sadly, an imperfect subject" (Re a Teenager (1988) 13 Fam LR 85 at 94).⁵³⁸

- 6.73 Indeed, as recently as 2018, the Family Court authorised parental consent to sterilisation of a 17 year old young person with intellectual disability who was distressed by her periods, concluding that:

I accept Dr C's evidence that the fact of the child's extended menstrual periods have caused her trauma; I also accept that, due to her severely impaired intellectual capacity, techniques that might otherwise be applied in normalising the impact upon her of experiencing extended periods of menstruation would not be successful. I also accept that the child's low IQ and cognitive impairment are such that her ability to understand reproduction, contraception, pregnancy and childbirth now and in the future are severely restricted and unlikely to improve to any real extent.

I consider that the proposed procedure will permit the child to enjoy her life to the fullest extent possible; it will free her from having to endure something she hates and which causes her stress and distress; it will also completely remove the risk that she continues to engage in self-harming behaviours as a manifestation of this stress and distress. Successful implementation of the proposed procedure will, in my view, free the child to be the 7 ½ year old child that she is and always will be.⁵³⁹

6.74 Menstrual blood management and menstrual health are circumstances faced by girls without disability. Yet, forced sterilisation would not be comprehended or justified for non-disabled girls. While sterilisation is justified by the Family Court in relation to menstruation for girls with disability, research indicates no differences in serious medical issues associated with menstruation for girls with intellectual disability, thus there is no medical need for girls with disability to be sterilised beyond the circumstances in which this would be done to non-disabled girls.⁵⁴⁰ These examples of Family Court authorisation of parental consent to non-therapeutic sterilisation on the basis of menstruation do not simply show gendered ableism in representing girls with disability as abnormal, incapable, burdensome and disposable menstruators. More than this, these examples dehumanise girls with disability by devaluing the significance of these common female and human experiences to girls with disability.

6.75 The gendered ableism of the judiciary is also reflected in comments in judgments concerning the fear that disabled women will re/produce children with genetic ‘defects’. For example, in 2004, the Family Court of Australia authorised the sterilisation of a 12 year old intellectually disabled girl with Tuberous sclerosis, a genetic disorder with a 50% inheritance risk factor. Although one out of two people born with tuberous sclerosis will lead ‘normal’ lives with no apparent intellectual dysfunction, the Court accepted evidence from a medical specialist that sterilisation was in the best interests of the young girl because:

*the result will be complete absence of menstruation and this will undoubtedly be of benefit to H who already appears to have substantial difficulties with cleanliness..... As a by-product of an absence of her uterus H will never become pregnant. Given the genetic nature of her disorder and the 50% inheritance risk thereof, this would in my view be of great benefit to H.*⁵⁴¹

6.76 Incapacity for parenthood is a common theme in applications for and Court authorisations of sterilisation of disabled females in Australia:

*It is clearly established that S is unfit to, and ought not, bear a child.*⁵⁴²

*Katie could not possibly care for a child.*⁵⁴³

*A pregnancy would be disastrous.*⁵⁴⁴

*It is clear that H has at least moderate intellectual disability.....she would be unable to care for a child if she were to become pregnant.*⁵⁴⁵

*It is understood and accepted that the child would never marry or enter into any relationship in which she would bear children. She is quite unable to understand the processes of conception and birth and would be quite unable to bear a child. Pregnancy would be most likely to have a highly detrimental effect upon her and should she become pregnant, for her own sake, her pregnancy would be terminated.*⁵⁴⁶

*If she were to be the victim of sexual assault, and to become pregnant, this would be a very complicated situation, both ethically and medically. The hysterectomy would remove the chance of an unwanted pregnancy and further medical complications associated with a pregnancy.*⁵⁴⁷

6.77 For example, in the case of *Re Katie*,⁵⁴⁸ her ‘attractive looks’ were considered to make her more ‘vulnerable’ to sexual abuse, and formed part of the Court’s rationale for her to be sterilised at the aged of 16:

It is highly unlikely that Katie will ever have the capacity to understand and voluntarily enter into a sexual relationship..... It is however well documented that disabled children are particularly vulnerable to sexual abuse and Katie is quite an attractive girl.

- 6.78 Similarly, in a case⁵⁴⁹ where the Court authorised the sterilisation of a 14 year old girl prior to the onset of menstruation, the judge stated:

it is unlikely she will have any form of relationship involving sexual intercourse. She could, of course, be the victim of a sexual assault and with her normal physical development and attractive looks that cannot be discounted.

- 6.79 In *JLS v JES*,⁵⁵⁰ where authorisation for sterilisation was sought for a 14 year old girl who was described as ‘*extremely severely handicapped*’, prevention of sexual abuse was a key factor in seeking the application. According to the Judge, the young girl’s mother ‘*expressed concern at the possibility of the child becoming pregnant through sexual abuse while out of the plaintiff’s direct supervision, as would increasingly occur as she approaches adulthood. The mother expresses a moral opposition to the concept of abortion....*’ A number of ‘experts’ supporting the application identified risk of sexual abuse as ‘evidence’ of why the sterilisation should be authorised:

“I do agree, especially as she is an attractive girl, that she is at great risk of pregnancy and also of pelvic infection as she develops sexual maturity.” [Consultant Neurologist]

“It would prevent a pregnancy, to the risk of which the child might become exposed in more social environments such as Respite Care, out of continual supervision by her mother. Having regard to her mental retardation she was incapable of communicating any symptoms relating to pregnancy. An epileptic episode during pregnancy would increase three or four times the risk of foetal abnormality.” [Consultant Obstetrician and Gynaecologist]

‘...it was unacceptable to have her exposed to the risk of becoming pregnant having regard to her mental retardation, epilepsy and condition generally.’ [Consultant Obstetrician and Gynaecologist]

- 6.80 In other cases, the young girls’ ‘behaviour’ with men was a consideration in authorising their sterilisation prior to the onset of their menstruation:

Ever since Elizabeth was a very young child, she was prone to run to men. If her mother takes her out she will go to any man, including strangers. On many occasions in public when the mother has not been holding Elizabeth tightly, she has run over to a man who is a complete stranger and taken his arm. She shows no fear and would happily go off with any man. She has to be physically restrained from chasing after men in public and throwing her arms around them.⁵⁵¹

S is likely to wander...[she] has a preference when singling out an adult for attention for men over women and particularly for men with beards.....S is generally solitary by choice.....[she] likes soft sticky textures and regularly engages in faecal smearing.....I have included the foregoing statements because they give something of an overall picture of the child. I would add that, if not common ground, it is clearly established that S is unfit to, and ought not, bear a child.⁵⁵²

...since the onset of sexual maturity she displays an affectionate promiscuity which is the characteristic of women with intellectual disability.⁵⁵³

- 6.81 In the case of *Re S*,⁵⁵⁴ sterilised at the age of 12 and described as having a ‘*mental age of no greater than 1 year old*’ with ‘*no prospect of any improvement in her already severely retarded mental state*’, the judge stated:

‘Although I agree that the risk of pregnancy, on its own, is not of sufficient likelihood as to indicate a need to submit her to a sterilisation procedure I would not dismiss the probability of sexual intercourse occurring.’

6.82 Despite the gendered ableism in the Family Court's decisions, the question of non-therapeutic sterilisation as discriminatory has been considered and rejected in the 1995 decision of *P v P*⁵⁵⁵ which was made in the years following *Marion's Case*. In this decision, the Full Family Court considered in greater detail the legal test for court authorisation. The Court considered whether the best interests test should include reference to non-discrimination in the form of a 'but for' question ('but for the disability, would this girl be sterilised?'). The Court dismissed the argument that the question of discrimination is relevant to court authorisation, stating that the application of a 'but for' test might be 'superficially attractive' because it 'is non-discriminatory and equates the intellectually handicapped person with the non-intellectually handicapped', but ultimately the test has the opposite effect and is 'conceptually incorrect'.⁵⁵⁶ The Full Family Court was conceptually incorrect because intellectual disability was an immutable and defining feature of intellectually disabled girls, and this rendered them fundamentally different and incomparable to girls without disability. This was explained in the specific context of the girl the subject of *P v P*, Lessli:

We are unconvinced that there is any relevant conclusion to be drawn with regard to the best interests of a particular child by an artificial exercise which compartmentalises a finding of fact about an immutable characteristic and then hypothesises that it were not so. Lessli's intellectual disability cannot be isolated as a factor and then "subtracted" from the constellation of facts about her, any more than one can simply imagine that she no longer suffers from epilepsy, or that she is infertile, or that she is not a female. Realistically, the effect of each of these factors is interactive and cumulative and it is their combined presence in the child which has led to the application before the Court. ...

The responsibility to assess the child's best interests is not furthered by compartmentalising one or more of her attributes and measuring the appropriateness of the proposed treatment against a hypothetical child. ...

If applied literally the test would mean that sterilisation could never be authorised other than for therapeutic medical reasons, because one would never contemplate the sterilisation of an intellectually normal 17-year-old other than for such reasons.

This is readily explicable upon the basis that an intellectually normal 17-year-old female, albeit suffering from epilepsy, can reasonably contemplate the likelihood that she may wish to engage in sexual intercourse for the purpose of having a child or children at any time during the next 35 years of her life, more commonly than not in the context of a marriage or like relationship and to raise and nurture such child or children. Further, she can consider and on advice decide upon the best method of contraception for her and to take or not to take contraceptives as she sees fit and to decide whether or not to have sexual intercourse as she sees fit. Finally, she can decide upon her own sterilisation, if not at the age of 17, at a time when she either decides as a mature adult that she does not wish to have a child or at a time when she does not wish to have further children. None of these considerations apply to a child like Lessli.⁵⁵⁷

6.83 The gendered ableist violence of forced sterilisation through the Family Court's welfare jurisdiction is completely denied in *P v P* by dehumanising Lessli as having opportunities in life that are fundamentally different to and less than non-disabled girls. Ultimately, it is a manifestation of ontological violence because the operation of the laws and the effects of the sterilisation procedure rhetorically and materially exclude women with disability from recognition as full females, legal subjects, and ultimately full humans.⁵⁵⁸

6.84 Family Court welfare jurisdiction authorisation of sterilisation of girls with disability reflects epistemic violence in marking the girls as inherently and eternally mentally incapable and as privileging the views of others, and ultimately denying to them the possibility of making the choice about sterilisation themselves. Dunn notes:

*Women with disability may decide - after being educated on non-therapeutic sterilisation - that they wish to undertake the procedure. That is their decision. However, a girl under the age of 18 should be allowed time to learn about her body; give her body time to develop and regulate; and then when she is older, she can make informed reproductive choices.*⁵⁵⁹

- 6.85 The Family Court's approach to sterilisation of girls with disability can be contrasted to the Family Court's jurisprudence on gender affirming medical treatments and procedures in relation to transgender young persons, where the focus has been on both acknowledging childhood is temporary and the evolving decision-making capacity of transgender young persons. Indeed, in the Family Court's decision of *Re Kelvin* which was celebrated as a legal victory for the transgender community, the majority of the Family Court distinguished the legal situation of transgender young persons whose decision-making capacity is constantly developing to that of girls with intellectual disability in sterilisation cases who were assumed to never be *Gillick* competent: 'In strict point of principle, Marion's case is binding upon this Court only in respect of non-therapeutic sterilization of a child who is not *Gillick* competent and who, by reason of disability, will never be *Gillick* competent'.⁵⁶⁰ Thus, in *Re Kelvin* the Family Court further entrenches ableist assumptions about girls with intellectual disability as incapable and ultimately as less than full legal subjects and full humans.

Guardianship Tribunal/Board Authorisation of Sterilisation

- 6.86 In the late 1980s, guardianship legislation was introduced across Australian states and territories. At the time, some identified guardianship tribunals and boards as the preferred forum for sterilisation authorisation away from the Family Court and state/territory Supreme Courts, on the basis the guardianship tribunals and boards have a more accessible procedural framework, greater expertise and knowledge about disability and a more empowering legal test for authorising sterilisation.⁵⁶¹ Irrespective of any perceived advantages of guardianship tribunals and boards over other forums, ultimately these legal forums still authorise forced sterilisation. As long as there are *any* judicial or tribunal forums for authorising sterilisation, legal and justice systems are sustaining sexual and reproductive violence against women and girls with disability.
- 6.87 We provide a detailed exploration of the impact of guardianship on women with disability in our submission to the Disability Royal Commission on guardianship.
- 6.88 Guardianship legislation is state and territory based. In this section we will discuss some of the common features of sterilisation under guardianship law, and also highlight some of the differences between state and territory jurisdictions.
- 6.89 Guardianship legislation enables substituted decision-making in relation to medical interventions. There is a hierarchy of medical procedures in terms of the level of guardianship tribunal/board oversight – at one end there are less significant medical interventions where guardianship law recognises the authority of third parties close to the individual (ranging in a hierarchy from guardians to family and friends) to consent whenever the need for consent arises without obtaining tribunal/board authorisation; in the mid-range are medical interventions that can be authorised by guardians who have been formally appointed under guardianship law; and at the other end of the spectrum are the most significant medical interventions (such as sterilisation) in relation to which tribunal/board authorisation is required for each specific intervention.
- 6.90 Guardianship legislation is disability-specific legislation, insofar as it applies to individuals who are considered to lack decision making capacity by reason of their disability. Thus, only people with disability (and particularly people with cognitive and psychosocial

disability) can ever be subjected to the legislation, and have their legal capacity denied through substituted decision-making. Thus, the legislation itself segregates people with disability into a separate legal space and creates the structural possibility for a lower threshold of legal violence against people with disability who come within the scope of the legislation. Denying legal capacity to people with disability on the basis of assumptions about the relationship between disability and mental capacity is ableist. The denial is premised on narrow expectations about how people access, understand and process information, make decisions, and communicate those decisions which reflects the experiences of abled people, and fails to acknowledge the provision of resources and supports to facilitate a broadened approach to decision-making. The legislation gives rise to epistemic violence in empowering third parties to interpret people with disability's experiences and circumstances, determine what is best for them and make decisions about what will happen to their bodies and lives: 'It denies disabled people the opportunity to have their own perceptions and views of their experiences and needs recognised by others, and it negates their status as political actors, capable of exercising resistance to legal and medical authority'.⁵⁶²

- 6.91 Guardianship law effaces its ableist violence by its historical associations with deinstitutionalisation and community living, and being oriented towards substituted decision-making that will purportedly support community participation and inclusion. These sentiments are evident in the principles contained in many of the state and territory guardianship Acts. Yet, this framing of guardianship law as delivering inclusion and participation is perverse, because these purported goals are arrived at through physical and epistemic violence, as explained by Spivakovsky and Steele:

First, guardianship law emerged from, and continues to work within, the temporal dynamics of a medicalised, curative imaginary. Not only is the appointment of a substitute decision-maker under guardianship law seen as necessary for producing a better future for the 'lacking' individual – graciously allowing the person to remain in the community by denying them legal recognition of their decisions. But additionally, this promise of a better, more 'inclusive' future in the community through guardianship, is pitted against what Altermark (2017) calls, the 'dark past' of institutionalisation.

Second, the future brought forth by guardianship law is one filled with (more) curative violence. To continue to be 'included' in the community going forward, disabled people deemed lacking decision-making capacity are not only denied legal recognition of their decisions, but they are also expected to receive and accept significant coercive, violent and harmful interventions in their bodies and lives. In the name of 'inclusion', they are expected to welcome having no choice in where they live, with whom they can reside, or indeed, when they can leave their place of residence. They are also expected to welcome having someone else consent to them being physically and/or mechanically restrained, to being chemically rendered docile, and to being secluded in their room or home.⁵⁶³

- 6.92 Turning specifically to guardianship law's authorisation of sterilisation, there is significant variation between jurisdictions in relation to the legal frameworks for authorisation. Some jurisdictions have considerably low thresholds for authorisation of sterilisation.
- 6.93 In New South Wales, the focus is on what is *necessary in relation to health*. Sterilisation is categorised as 'special treatment'. 'Special treatment' is defined as including 'any treatment that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out'.⁵⁶⁴ Special treatment can only take place pursuant to authorisation of the New South Wales Civil and Administrative Tribunal (NCAT). NCAT must not consent unless it is 'satisfied that the treatment is the most appropriate form of treatment for promoting and maintaining the patient's health and well-being' and 'it

is satisfied that the treatment is necessary (a) to save the patient's life, or (b) to prevent serious damage to the patient's health'.⁵⁶⁵ NCAT must also be satisfied that 'the treatment is the most appropriate form of treatment for promoting and maintaining the patient's health and well-being'.⁵⁶⁶ Of all the states and territories, NSW has the highest threshold to meet for authorising non-consensual sterilisation, and it is notable that in the past 10 years it has dismissed a number of sterilisation applications that would arguably have fit within other state and territory legal frameworks for sterilisation. Ultimately, however, any legal provision for authorisation of sterilisation (irrespective of how high the threshold) is problematic and must be abolished.

- 6.94 In contrast, under Queensland and South Australia guardianship law sterilisation can be authorised where it is *medically necessary, or for contraceptive or menstrual purposes*. Section 70 of the *Guardianship and Administration Act 2000* (Qld) provides that the Queensland Civil and Administrative Tribunal (QCAT) can consent to sterilisation of 'an adult with impaired capacity' only if it is satisfied that 'the sterilisation is medically necessary', 'the adult is, or is likely to be, sexually active and there is no method of contraception that could reasonably be expected to be successfully applied', and 'if the adult is female: the adult has problems with menstruation and cessation of menstruation by sterilisation is the only practicable way of overcoming the problems'. Additionally, QCAT must be satisfied that 'the sterilisation can not reasonably be postponed' and 'the adult is unlikely, in the foreseeable future, have capacity for decisions about sterilisation'.⁵⁶⁷ The ground of medical necessity will not be met if the sterilisation is 'for eugenic reasons' or 'to remove the risk of pregnancy resulting from sexual abuse'.⁵⁶⁸ In making its decision to consent to sterilisation, QCAT must take into account 'alternative forms of health care, including other sterilisation procedures, available or likely to become available in the foreseeable future', and 'the nature and extent of short-term, or long-term, significant risks associated with the proposed procedure and available alternative forms of health care, including other sterilisation procedures'.⁵⁶⁹ In a similar vein to Queensland, under South Australian guardianship law, 'sterilisation' is a 'prescribed treatment' that can be authorised by the South Australian Civil and Administrative Tribunal (SACAT) for non-therapeutic reasons. SACAT can consent to sterilisation that is 'therapeutically necessary'.⁵⁷⁰ SACAT can also consent to sterilisation if it is satisfied 'there is no likelihood of the person acquiring at any time the capacity to give an effective consent', 'the person is physically capable of procreation', and either 'the person is, or is likely to be, sexually active, and there is no method of contraception that could, in all the circumstances, reasonably be expected to be successfully applied' or 'in the case of a woman, cessation of her menstrual cycle would be in her best interests and would be the only reasonably practicable way of dealing with the social, sanitary or other problems associated with her menstruation'.⁵⁷¹
- 6.95 The difference between the New South Wales and Queensland/South Australia approaches is striking. Indeed, in the table of sterilisation cases earlier in this section, there are 8 QCAT decisions approving sterilisation applications and none dismissing sterilisation applications (noting, of course, that this data is not comprehensive because decisions are not routinely published). Of particular concern is that in Queensland and South Australia, sterilisation can be authorised for contraception or menstrual management. As discussed earlier, it is incomprehensible that forced sterilisation would be allowed for women and girls without disability for contraception or menstrual management. While this in itself is ableist, the contexts in which these laws are applied also reflect gendered ableism. For example, in *Re AX*, sterilisation of AX was authorised by QCAT for the purpose of menstrual management. AX was described as 31 years old and with an intellectual disability and epilepsy. AX had not been able to manage her personal care needs independently during periods of menstruation and was reliant on her mother for assistance. The aim of AX's parents was for AX to have some level of independence but this was impossible when she was so physically reliant on her mother for her care during her periods. This was a key consideration in QCAT authorising the sterilisation:

The Tribunal also notes that Ms AX is also incapable of independent living whilst she continues to experience menstrual difficulties. The Tribunal accepts the evidence of Ms AX's parents that they are aging and would like to see Ms AX in an independent living situation. Ms AX's activities during menstruation are also limited due to the fact that she is totally dependent on her mother for assistance. The Tribunal also notes the impact that this dependence has on Ms AX's mother. The Tribunal also notes that in the normal course of events Ms AX would continue to have periods for the next twenty years.⁵⁷²

- 6.96 This decision echoes two of our observations made in relation to the Family Court. One is authorisation of sterilisation in a context of responsabilising the families (and more specifically mothers) for the personal care needs of women with disability, when there should be sufficient resources and support available from the government to avoid a situation where the only two options are informal family support or sterilisation. The second is authorisation of sterilisation on the basis of assumptions that menstruation has no purpose or utility for women with disability. While the Queensland legislation states that sterilisation will not be 'medically necessary' if it is 'for eugenic reasons',⁵⁷³ this still leaves open the possibility of 'eugenic reasons' underpinning sterilisation for contraception or menstrual management. Moreover, the mere fact of the availability of legal non-consensual sterilisation only for women and girls with disability itself reflects eugenics logics embedded within the legislation at a structural level,⁵⁷⁴ irrespective of how the legislation might be applied in relation to a specific individual.
- 6.97 A third approach to authorisation of sterilisation under guardianship law is found in Western Australia, Australian Capital Territory, Tasmania and Queensland (only in relation to children) which focuses on 'best interests'. In the Australian Capital Territory 'reproductive sterilisation' and 'hysterectomy' are categorised as 'prescribed medical procedures' requiring consent of the ACT Civil and Administrative Tribunal (ACAT) where 'the procedure would be in the person's best interests' and 'the person is not competent to give consent and is not likely to become competent in the foreseeable future'.⁵⁷⁵ In determining that the procedure is in the individual's best interests, ACAT must take into account 'the wishes of the person, so far as they can be ascertained', 'what would happen if it were not carried out', 'what alternative treatments are available', and 'whether it can be postponed because better treatments may become available'.⁵⁷⁶ Similarly, in Tasmania, sterilisation is a 'special medical treatment' which must be consented to by the Guardianship and Administration Board (TASGAB), and such consent can only be given where the 'person is incapable of giving consent' and it would be in the 'best interests' of the person.⁵⁷⁷ In determining that the sterilisation is in the individual's best interests, the Board will take into account 'the wishes of that person, so far as they can be ascertained', 'the consequences to that person if the proposed treatment is not carried out', and 'any alternative treatment available to that person'.⁵⁷⁸ Likewise, in Western Australia, sterilisation cannot occur unless the guardian and the State Administrative Tribunal (SAT) consent, and the tribunal can only consent where the sterilisation is in the individual's 'best interests'.⁵⁷⁹ The Act does not elaborate on the concept of 'best interests' via-a-vis SAT.
- 6.98 The SA, TAS and WA 'best interests' approach sets a low threshold for authorising sterilisation, because of judgements of what constitutes 'best interests'. For example, in *QN (Medical Consent)*,⁵⁸⁰ TASGAB decided it was in QN's best interests to be sterilised to prevent pregnancy related to her being in an intimate relationship. Dr Keating, QN's treating gynaecologist, made an application to TASGAB to provide consent for QN to have a sterilisation procedure as a form of permanent contraception. QN is described in the judgment as a 19 year old woman with Tristomy 21 (Down syndrome). Dr Keating reported that QN had been trialed on a number of oral contraceptives which were not well tolerated and resulted in significant dysphoria and mood disturbance. The Board heard evidence from FH (QN's mother) that QN enjoys male company more than female company and

had shown interest in particular male persons in the past. FH advised that her daughter had fallen in love a number of times and had experimented with romantic relationships, kissing and cuddling. FH also indicated that her daughter has requested that her boyfriend be allowed to come over and sleep in her bed with her. Dr Keating indicated that QN had sexualised behaviour and the chances of QN having sexual activity were high. Dr Keating indicated it would be impossible for QN to be able to keep and care for a baby. Dr Williams, a paediatrician, reported that: ‘A pregnancy would be disastrous and life threatening for QN is vulnerable to non-consensual sexual intercourse’. The Tasmanian Guardianship and Administration Board (TASGAB) concluded that the sterilisation would be in her best interests, particularly because this would allow her to remain included in the community:

The Board gives weight to the fact that QN appears to be participating as fully as she is able in life, enjoying socialising with others and living a life significantly less isolate than one she previously enjoyed. The Board acknowledges QN’s human right to freely engage in contact with persons of both sexes and the right to enter intimate relationships if she so chooses. The Board notes the views of those present at hearing that it is highly likely that QN may engage in sexual relationships and appears to have opportunity to do so. The least restrictive option is therefore to allow her to enjoy her current lifestyle and not to socially isolate her from male persons so as to ensure she does not have sexual relationships and therefore to prevent pregnancy. To do so would result in a severe reduction of QN’s quality of life and freedom to engage in social activity.⁵⁸¹

6.99 The reasoning by TASGAB highlights a core tension in guardianship law identified earlier – that the interventions in guardianship law are necessary to bring about future wellbeing, at the same time that the intervention itself depletes wellbeing and excludes individuals from full legal personhood and citizenship. In QN’s case, her human rights, community inclusion, and happiness and fulfillment in the context of her intimate relationship is a justifiable basis on which to authorise sterilisation even when this very intervention can cause ongoing trauma and long term health impacts and also denies to her the possibility of having children which many women in intimate relationships might wish to do.

6.100 In relation to children, QCAT can also consent to sterilisation of a ‘child with an impairment’ where this is in the child’s best interests.⁵⁸² The sterilisation is in the child’s best interests only if ‘the sterilisation is medically necessary’, ‘the child is, or is likely to be, sexually active and there is no method of contraception that could reasonably be expected to be successfully applied’, or ‘if the child is female—the child has problems with menstruation and cessation of menstruation by sterilisation is the only practicable way of overcoming the problems’,⁵⁸³ and additionally ‘the child’s impairment results in a substantial reduction of the child’s capacity for communication, social interaction and learning’, ‘the child’s impairment is, or is likely to be, permanent and there is a reasonable likelihood, when the child turns 18, the child will have impaired capacity for consenting to sterilisation’, ‘the sterilisation can not reasonably be postponed’, and ‘the sterilisation is otherwise in the child’s best interests’.⁵⁸⁴ The legislation does note that sterilisation will not be in the child’s best interests if it is ‘for eugenic reasons’ or ‘to remove the risk of pregnancy resulting from sexual abuse’.⁵⁸⁵ QCAT must take into account ‘the wellbeing of the child’, ‘alternative forms of health care that have proven to be inadequate in relation to the child’, ‘alternative forms of health care that are available, or likely to become available, in the foreseeable future’, and ‘the nature and extent of short-term, or long-term, significant risks associated with the proposed sterilisation and available alternative forms of health care’.⁵⁸⁶ QCAT’s powers in relation to sterilisation of children reflect many of the reasons for authorisation of sterilisation by the Family Court (e.g., menstruation, sexual activity) and thus the criticisms we made earlier of the Family Court’s welfare jurisdiction also apply here.

6.101 In Victoria, a slightly different approach is taken. Under the *Guardianship and Administration Act 2019 (Vic)*, the Victorian Civil and Administrative Tribunal (VCAT) can

consent to ‘sterilisation’ as a ‘special medical procedure’ in relation to an individual who ‘does not have decision-making capacity in relation to giving consent’ and ‘is not likely to have decision-making capacity in relation to giving consent within a reasonable time’.⁵⁸⁷ However, instead of the best interests requirement that applied under the state’s previous guardianship legislation, the question is now whether ‘the patient would consent to the carrying out of the special medical procedure if the patient had decision-making capacity in relation to giving consent’.⁵⁸⁸ If the individual has not expressed their preferences then ‘VCAT must give consideration to the patient’s values whether— (i) expressed other than by way of a values directive; or (ii) inferred from the patient’s life’.⁵⁸⁹ While this test uses different wording than ‘best interests’ and is directed towards trying to identify what the woman herself might want, ultimately it is still a system of substituted decision-making that privileges the views and insights of third parties (including their interpretations of what women might want). As noted earlier, the entrenched structural ableism in health, disability service and legal systems means it is likely the views and insights of third parties will be informed by gendered ableist approaches to women with disability.

- 6.102 Although there is some inconsistency between jurisdictions in relation to sterilisation, the *Protocol for Special Medical Procedures (Sterilisation)* was ‘designed to assist the various Australian guardianship tribunals in exercising this power, and to promote consistency across the jurisdictions when dealing with an application for the sterilisation of a person’.⁵⁹⁰ This Protocol provides that tribunals should be guided by ‘same human rights’ (‘The right of all persons to the same basic human rights regardless of a particular person’s capacity’) and ‘individual value and autonomy’ (‘A person’s right to respect for his or her human worth and dignity as an individual’).⁵⁹¹ Yet irrespective of how tribunals/boards exercise their powers in specific cases, these human rights aspirations are undercut at the level of the legislation itself given forced sterilisation and substituted decision-making themselves violate human rights.

Menstrual Suppression and Contraception

- 6.103 Coercive and non-consensual contraception and menstrual suppression involves use of devices and drugs to prevent menstruation and/or reproduction. These are known collectively as ‘long acting reversible contraception’ (LARC). This has been described as follows:

*LARC methods comprise intrauterine contraception (including copper intrauterine devices and the levonorgestrel intrauterine system), injectables, and implantable progestogens. LARC methods are the most effective modern contraceptive methods for preventing unintended pregnancy. They are long-acting, reliable, safe, cost-effective, and have additional non-contraceptive benefits for a broad range of women seeking spacing or limiting methods of contraception. LARC methods do not rely on user adherence and are also suitable for women with medical disorders.*⁵⁹²

- 6.104 LARC are used consensually by many women for the purpose of managing menstruation and fertility, and in this context have been observed as increasing in popularity as compared to sterilisation.⁵⁹³ However, LARC also have a history of being used non-consensually and coercively in relation to disabled women and other marginalised groups of women. For example, LARC have been used systematically in relation to criminalised women, Indigenous and racialized women in developed countries, and marginalised women in developing countries.⁵⁹⁴ LARC are commonly used non-consensually or coercively (including deceptively) in relation to women and girls with disability. Women and girls with disability are more likely than their non-disabled peers to be prescribed long-acting, injectable contraceptives and are far less likely to be prescribed oral

contraceptives.⁵⁹⁵ In addition, women with disability are much less likely to be involved in choice and decision-making around the type of contraception they use. In the case of women with intellectual disability, the decision about type of contraception is almost exclusively made by someone else, such as a doctor and/or guardian, parent, or carer.⁵⁹⁶ WWDA further notes:

Forced contraception practices are often undertaken under the guise of ‘behaviour management’ strategies or treatment for ‘unwanted’ or ‘offending sexual behaviour’. These practices are rarely, if ever, subject to independent monitoring or review. For example, the use of Depo Provera and other long acting contraceptive medications, used to suppress menstruation in women and girls with disabilities living in institutions or other residential settings, often occurs through an ‘arrangement’ between the institution or residential setting and a doctor. These types of contraceptives are used to suppress menstruation in women and girls with disabilities as a first and only response to what is deemed by others as ‘inappropriate behaviour’, such as removing sanitary pads in public or not disposing of them appropriately in a waste-bin. Sex education, menstrual management strategies and supports for the individuals and families concerned are rarely available or even considered.⁵⁹⁷

- 6.105 WWDA has also observed use of LARC in disability residential settings to increase efficiency of care provision:

A male disability support worker from a government funded group home, boasted that the female residents in the group home where he worked, were all “given the Primolut” without the placebo tablets so that they didn’t get their periods. When asked why this was the practice, the disability support worker replied that “It’s not our job to deal with periods” and that it “makes it easier for us to look after them.”⁵⁹⁸

- 6.106 Tilley et al. discuss UK research highlighting similar issues:

In the broader context of choice and control over contraception, Michelle McCarthy’s (2009) research indicates that contraception is prescribed at an earlier age and continues later than for non-disabled women, with an over reliance on carers to communicate with doctors. McCarthy (2009) observed a disregard for the health consequences of using Depo Provera for long periods and suggests that contraceptive devices are being used as a response to the danger of sexual abuse and rape; the ‘just in case’ approach, justifying contraceptive interventions even amongst women who are not sexually active, on the basis that something might happen to them at a future point. The rationale is not far removed from the case that was being made to sterilize institutionalized women in the so-called ‘Eugenic era’. McCarthy (2009) also noted an unwarranted and exaggerated fear of the consequences of pregnancy; and that decisions concerning contraception are informed by convenience for staff in managing women’s periods. She concluded that her interviewees lacked autonomy or knowledge of alternatives, and played a largely passive role in determining whether to use contraception, and the range of choices available. She points out that whereas sterilization is subject to legal oversight no such safeguards exist for the use of long-term contraception such as Depo Provera: ‘when a woman...is put on contraception for most or all of her reproductive life this is arguably a chemical sterilization, yet it has no legal scrutiny’ (McCarthy 2010, 264).⁵⁹⁹

- 6.107 These practices are rarely, if ever, subject to independent monitoring or review and can also be legally authorised, as we will discuss further below. Their temporary and less-invasive nature might mean they are not considered as serious in political terms in contrast to sterilisation, as noted by Steele and Goldblatt:

The ‘temporary’ and ‘non-invasive’ nature of menstrual suppressant drugs might

render them subject to less legal and political scrutiny because they are not viewed as impacting as significantly on bodily integrity and autonomy because they do not involve the surgical cutting of the body, even though they are still non-consensual, involve entry of substances into the body and are similarly underpinned by problematic assumptions about disability, gender, and menstruation.⁶⁰⁰

- 6.108 While LARC is ‘temporary’ in the sense that there is always the possibility for the drugs to be ceased and their impacts reversed, in practice they are often administered for years and decades with little medical review and scrutiny of their purpose, necessity and side effects on those to whom they are prescribed. This then means if women and girls with disability are deprescribed LARC, they can experience side effects such as physical pain which can provide perverse incentives to resume prescription. Additional to the impacts of LARC on personal integrity and autonomy, the impacts of LARC can include certain gynaecological cancers, osteoporosis, increased weight gain, elevated prolactin concentrations (which can cause infertility, menopausal symptoms, milk discharge from the breasts, hyperprolactinemia, hypothyroidism).⁶⁰¹ Moreover, because LARC prevents menstruation, use of LARC can also mask the onset of menopause which can then mean that physical and psychological experiences associated with menopause are ignored.⁶⁰² Consequently, this can potentially form a basis on which women with disability are subject to further coercive interventions to manage their ‘challenging behaviour’ associated with onset of menopause or the pain of undiagnosed cancer or osteoporosis. The Victorian Senior Practitioner summarised some of these risks:

Depo-Provera decreases estrogen levels, which leads to reduced bone density and strength (Berenson, Breitzkopf, Grady, Rickert, & Thomas, 2004). For those women who may not be able to exercise, or have limited exercise, there is an increased risk of losing overall bone strength. Reduced bone strength is likely to lead to bone fractures and breaks. Taking the oral contraceptive pill (ethinylloestradiol) can increase the risk of blood clots by three to five times, which can cause heart attacks and stroke. Similarly, those who are unable to exercise, or have limited exercise, are at increased risk of blood clots (Trenor et al., 2011; Voelker, 2011). Considering the prevalence of complex communication needs in this population, people may be unable to report pain or injury. This compounds the health risks, as people may be experiencing severe pain on a daily basis (Stallard, Williams, Lenton & Velleman, 2001).⁶⁰³

- 6.109 A current boxed warning for Depo-Provera directed towards US residents states:

Warning: Loss of Bone Mineral Density

Women who use Depo-Provera Contraceptive Injection (Depo-Provera CI) may lose significant bone mineral density. Bone loss is greater with increasing duration of use and may not be completely reversible

It is unknown if use of Depo-Provera CI during adolescence or early adulthood, a critical period of bone accretion, will reduce peak bone mass and increase the risk for osteoporotic fracture in later life

Depo-Provera CI is not recommended as a long-term (i.e., longer than 2 years) birth control method unless other options are considered inadequate ...⁶⁰⁴

- 6.110 Pfizer’s prescribing information for medical practitioners additionally notes:

Depo-Provera CI can pose an additional risk in patients with risk factors for osteoporosis (e.g., metabolic bone disease, chronic alcohol and/or tobacco use, anorexia nervosa, strong family history of osteoporosis or chronic use of drugs that can reduce bone mass such as anticonvulsants or corticosteroids). ...

Women who have or have had a history of breast cancer should not use hormonal contraceptives, including Depo-Provera CI, because breast cancer may be hormonally sensitive Women with a strong family history of breast cancer should be monitored with particular care. ...

Monitor patients who have a history of depression and do not re-administer Depo-Provera CI if depression recurs. ...

*Return to ovulation and fertility is likely to be delayed after stopping Depo-Provera CI.
...*

A woman who is taking hormonal contraceptive should have a yearly visit with her healthcare provider for a blood pressure check and for other indicated healthcare.⁶⁰⁵

6.111 The information on Depo-Provera makes clear that there are significant health risks with use of this LARC, particularly for longer-term use, and that this can be exacerbated for women with pre-existing conditions such as depression. Moreover, the information emphasises the importance of doctors monitoring usage of Depo-Provera, including through annual medical check-ups. Unfortunately, some women with disability who are under guardianship and subject to non-consensual contraception can be in a state of ‘set and forget’ and not have regular medical check-ups let alone regular review of contraception prescriptions. This is particularly the case if women are additionally socially isolated, financially disadvantaged and in insecure housing such as boarding houses or in disability group homes (all circumstances that might themselves have been enabled through the substitute decisions or neglect of guardians and financial managers).

6.112 Challenging the depoliticisation and non-violence of LARCs, Winters and McLaughlin propose that LARCs should be conceptualised as ‘soft sterilisation’:

Each of the concepts outlined—reproductive justice, involuntary sterilization, and LARCs—is critical to soft sterilization. Involuntary sterilization has been used as a mechanism to limit the reproduction of “undesirable” groups—namely those who differ from the hegemonic norms of race, sexuality, age, class, and criminal background. The unique properties of LARC—being highly effective, non-agentive, and provider controlled—create an opportunity for non-profits and state agencies to achieve the same outcome of previous sterilization programs—reproductive control of marginalized people—without the stigma of sterilization. The technology of LARCs allows for the state to obfuscate the process of reproductive control through the focus on the reversibility of the device. Although LARCs are reversible, thus reinstating the LARC user’s fertility upon removal, the power and ability to remove the device belong to the medical provider. With LARC programs operating through jails, child and family welfare, health-care providers, and non-profit organizations, the convergence of systems of care and systems of punishment inextricably connect reproductive control with the carceral state. Therefore, to achieve reproductive liberation and autonomy, the carceral state must be abolished.⁶⁰⁶

6.113 The idea of LARC as a form of violence and control in and of itself, as well as being part of a broader network of control (including use of other forms of restrictive practice) is reflected in findings from a report by the Victorian Senior Practitioner team on the use of menstrual suppression as a restrictive intervention from 2008 to 2019. The study report noted that:

The people in the study cohort also reported as being subject to the use of a range of other restrictive practices during the time period they were also reported as being subject to the use of menstrual suppression as a chemical restraint. These restrictive practices included other chemical restraint, mechanical restraint, seclusion, other restraints (such as environmental), or a combination of these restraints.⁶⁰⁷

- 6.114 WWDA urges the Royal Commission to explore the interconnections between LARC and other restrictive practices.
- 6.115 There are no available data on LARC.⁶⁰⁸ In part this is because of: LARC being implanted or prescribed in the context of general visits to the GP as part of routine medical advice and treatment, the lack of, and/or lower legal oversight of these interventions, and the lack of NDISQSC data collection specifically in relation to LARC (irrespective whether the use of LARC is an authorised or unauthorised restrictive practice).
- 6.116 Use of LARC also reflects compounding effects of intersectional oppression and settler colonialism for Indigenous women and girls with disability and other marginalised groups. For example, Shea observes that:

In more developed countries, Depo Provera is disproportionately prescribed to society's most marginalized and disadvantaged groups. And recipients are often not fully informed of the side effects and potential health risks of the drug. These groups include: Aboriginal women; women with disabilities; incarcerated women; girls and women in long-term care facilities; women with drug and alcohol addiction problems; poor women; women of colour, and; teenagers.

The patterns are telling; in the United Kingdom Depo is used most often by Asian and West Indian women, in Australia by Aboriginal women, and in New Zealand by Maori and Pacific Island women.⁶⁰⁹

National Disability Insurance Scheme (NDIS) Regulation of LARC

- 6.117 The National Disability Insurance Scheme (NDIS) is a universal scheme that funds 'reasonable and necessary' supports for Australians with permanent and significant disability.⁶¹⁰ The *National Disability Insurance Scheme Act 2013* (Cth) clearly articulates that one of the objects of the NDIS is to 'give effect to Australia's obligations under the *Convention on the Rights of Persons with Disabilities*'.⁶¹¹ Moreover, the NDIS has been framed as enhancing autonomy and inclusion of people with disability; the objects of the NDIS Act include:

support the independence and social and economic participation of people with disability; ...

enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports;⁶¹²

- 6.118 Despite its ideals, the NDIS legislative framework regulates, rather than prohibits, use of LARC in NDIS funded services, as part of its regulation of restrictive practices. Specifically, they are regulated as a form of restrictive practices through the *National Disability Insurance Scheme (Restrictive Practices and Behaviour Support) Rules 2018* (Cth) (NDIS RP Rules), in concert with State/Territory substitute decision-making laws.
- 6.119 'Restrictive practice' is defined as 'any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability'.⁶¹³ 'Regulated restrictive practices' in the context of the NDIS are defined as:

A restrictive practice is a regulated restrictive practice if it is or involves any of the following:

(a) seclusion, which is the sole confinement of a person with disability in a room or a physical space at any hour of the day or night where voluntary exit is prevented, or not facilitated, or it is implied that voluntary exit is not permitted;

(b) **chemical restraint**, which is the use of medication or chemical substance for the primary purpose of influencing a person's behaviour. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or a physical condition;

(c) **mechanical restraint**, which is the use of a device to prevent, restrict, or subdue a person's movement for the primary purpose of influencing a person's behaviour but does not include the use of devices for therapeutic or non-behavioural purposes;

(d) **physical restraint**, which is the use or action of physical force to prevent, restrict or subdue movement of a person's body, or part of their body, for the primary purpose of influencing their behaviour. Physical restraint does not include the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person;

(e) **environmental restraint**, which restrict a person's free access to all parts of their environment, including items or activities.⁶¹⁴

6.120 LARC can constitute chemical restraint. However, its status as chemical restraint runs along the therapeutic/non-therapeutic divide also apparent in the context of Family Law authorisation of sterilisation of girls with disability, discussed earlier. The definition of 'regulated restrictive practice' above makes clear that LARC will only be chemical restraint where it is used 'for the primary purpose of *influencing a person's behaviour*', but not where it is used as *medication for the treatment of* 'a diagnosed mental disorder, a physical illness or a physical condition'. Where LARC is used for a medical condition, it will not be subject to the NDISQSC regulation and oversight. This therapeutic/non-therapeutic division in the NDISQSC approach to LARC as chemical restraint is not scientifically objective – what counts as a medical condition is socially and economically contingent and gendered. Thus, there is significant scope for coercive interventions to be framed as required for medical conditions and thus completely outside of the NDISQSC regulatory and oversight framework. Moreover, use of LARC as chemical restraint 'for the primary purpose of influencing a person's behaviour' individualises, pathologises and neutralises women and girls with disability's legitimate responses to their living arrangements and experiences of oppression, structural discrimination and violence:

- Legitimate expressions of loneliness, boredom, hurt, frustration and anger in response to lack of genuine and trauma-informed care and companionship by staff
- Legitimate expressions of loneliness, boredom, hurt, frustration and anger in response to lack of meaningful activities and purpose in their living arrangements and daily routines
- Legitimate expressions of distress, fear and anger in response to perpetration of violence, abuse, neglect and exploitation by staff
- Legitimate expressions of distress, sadness, grief and anger in response to denial of familial, intimate and social relationships
- Legitimate expressions of distress and discomfort in response to failure to recognise and seek assistance for pain or medical conditions
- Legitimate responses of resistance to their living conditions and treatment

6.121 NDISQSC states that medication for menstrual suppression is a restrictive practice, but not when the menstrual suppression is for medical reasons:

The use of medication for menstrual suppression due to behaviours of concern for example, distress and hygiene (e.g. smearing) is a chemical restraint under the NDIS (Restrictive Practices and Behaviour Support) Rules 2018. The use of medication for menstrual management is not considered chemical restraint when:

1) it is prescribed for the treatment of a diagnosed medical condition (e.g., endometriosis); or

2) the person with disability has requested and consented to this treatment.

It is important that women with disability are provided with information in a meaningful way to support their decision-making about their reproductive and sexual health. Informed consent needs to be documented and the person must also understand that they can withdraw consent at any time.

Menstrual suppression should only be considered when other options have failed or if there are significant gynaecological or other medical reasons. Alternative strategies should be trialled to solve issues such as fear of blood, smearing, hygiene problems and/or pain and distress.⁶¹⁵

- 6.122 In relation to children and young people, NDISQSC has explicitly stated that the following would be a regulated restrictive practice:

Using medication for menstrual suppression for convenience or hygiene reasons (without the young person having any choice or control); or using medication with sedative quality for aggression (chemical restraint)⁶¹⁶

- 6.123 Use of LARC in disability services has also been considered at state/territory level. For example, in the context of explaining the NSW Government's role in overseeing authorisation of restrictive practices by registered NDIS providers, NSW Family and Community Services defines 'chemical restraint' as 'a restrictive practice that involves the use of a medication or chemical substance, often referred to as psychotropic medications, for the primary purpose of influencing a person's behaviour'.⁶¹⁷ It identifies 'hormonal medications' as one of 'five major categories of medications that may be used to alter behaviour'.⁶¹⁸ It explains: 'Hormonal medications have different purposes and effects for women and men. Women take hormonal medications such as Mestranol for contraception, for gynaecological issues, or to suppress menstruation. Men may take hormonal medications such as Cyproterone acetate to deliberately reduce sexual arousal'.⁶¹⁹ The Victorian Senior Practitioner utilises a similar definition and gives as one example of chemical restraint: 'menstruation suppression: It is considered the woman is unable to manage her period and the service uses contraceptive devices to suppress the monthly break'.⁶²⁰ It has stated that '[a]ccording to the *Disability Act 2006*, menstrual suppression is a reportable chemical restraint if it is used to stop behaviours of concern and is not treatment for an underlying health issue'.⁶²¹ These definitions arguably broaden the scope of when use of LARC becomes restrictive practices.

- 6.124 It is troubling that NDISQSC has stated that 'behaviours of concern' in relation to menstruation can be 'distress and hygiene (e.g. smearing)', because of the socially and politically contingent nature of societal responses to menstruation:

Conventionally, menstruation is understood as a natural bodily process associated with people sexed as female. In seeking to complicate and disrupt this view, critical menstruation scholarship explores menstruation as a social, political and cultural phenomenon and in doing so highlights the role of menstruation in social injustice. ...

In emphasising the constructed and contingent meanings of menstruation, critical menstruation scholarship draws attention to the role of stigma both in societal

*understandings of menstruation and the socio-political and material experiences of menstruators. In particular, menstruation is equated with menstrual blood, which in turn is associated with dirtiness, impurity, disease, and irrationality and rationalises responses to menstruating bodies characterised by discrimination, exclusion and violence.*⁶²²

- 6.125 In this context of menstruation as a stigmatised and shameful practice, women and girls with disability are positioned as abnormal menstruators:

Scholars engaged in critical menstruation studies have explored the place of menstruation in women's abjection and marginalization. This is exacerbated for women (including those with disabilities) who are positioned outside of normative constructs of the white, able, middle-class woman. ...

*In a context where women are constructed as deficient vis-à-vis men, feminist disability scholars have argued that women and girls with disabilities are positioned against norms of the able woman thus giving rise to greater degrees and different forms of discrimination, violence, and marginalization. Women and girls with disabilities are viewed as mentally and physically incapable of meeting gendered norms to conceal their menstruation and to control their sexuality and manage their fertility. Moreover, in being unable to meet gendered norms of motherhood and sexuality, women and girls with disabilities are viewed as burdens on those who provide care to them, with menstruation being seen as an additional and superfluous source of labor and time for carers because women and girls with disabilities are viewed as not needing menstruation for reproductive reasons. As such, there are assumptions operating on at least three levels: a) that women and girls with disabilities should conceal and control their menstruation, b) that women and girls with disabilities are incapable of doing so, and c) that it is inefficient and unnecessary for others to support women and girls with disabilities to menstruate.*⁶²³

- 6.126 In light of these critical observations, WWDA urges the Disability Royal Commission to interrogate the gendered ableist logics embedded in menstrual behaviours of concern:

- From whose vantage point are these behaviours considered to be 'of concern' of such a significant nature so as to warrant non-consensual intervention?
- To what extent are menstrual-related behaviours 'of concern' to service providers because menstruation is socially stigmatised, there are cultural expectations menstrual blood will be concealed and hidden, the sight of menstrual blood should elicit shame in those whose blood is seen and disgust in those who see it, menstruation is a sign of female fertility and sexuality which causes unease, and menstruation is a taboo topic which should not be spoken about?
- To what extent is the sight or contact with menstrual blood (eg in the context of needing to provide personal care or clean any 'smearing') considered more disgusting than other bodily excretions such as urine, mucous, semen or faeces, and how does this impact on how labour involved in attending to menstruation is seen as more burdensome, superfluous, or risky than other personal care and cleaning labour performed by disability services?

- 6.127 As conditions of their registration, registered NDIS providers who use restrictive practices in the course of delivering NDIS supports must not use these 'where the relevant State and Territory prohibits such use', must use them 'in accordance with State and Territory authorisation processes and a behaviour support plan', and the use must 'be recorded by the provider and reported to the Commissioner so that the Commissioner can effectively monitor the use of regulated restrictive practices in the NDIS'.⁶²⁴

6.128 The behaviour support plan must be developed by ‘an NDIS behaviour support practitioner engaged by the provider’ or, ‘if the provider is an NDIS behaviour support practitioner—that person’.⁶²⁵ A behaviour support plan containing regulated restrictive practices ‘must be developed in accordance with any authorisation process (however described) in the State or Territory in which the regulated restrictive practice is, or is proposed to be, used’.⁶²⁶ In developing and reviewing the behaviour support plan, the specialist behaviour support provider must take all reasonable steps to:

(a) reduce and eliminate the need for the use of regulated restrictive practices in relation to the person with disability; and

(b) take into account any previous behaviour support assessments and other assessments; and

(c) make changes within the environment of the person with disability that may reduce or remove the need for the use of regulated restrictive practices; and

(d) consult with the person with disability; and

(e) consult with the person with disability’s family, carers, guardian or other relevant person; and

(f) consult with the registered NDIS provider who may use the regulated restrictive practice and other relevant specialists.⁶²⁷

6.129 Moreover, ‘the plan must include strategies that are evidence-based, person-centred and proactive and that address the person with disability’s needs and the functions of the behaviour’.⁶²⁸ The restrictive practice should:

- *be used only as a last resort in response to risk of harm to the person with disability or others, and after the provider has explored and applied evidence-based, person-centred and proactive strategies; and*
- *be the least restrictive response possible in the circumstances to ensure the safety of the person or others; and*
- *reduce the risk of harm to the person with disability or others; and*
- *be in proportion to the potential negative consequence or risk of harm; and*
- *be used for the shortest possible time to ensure the safety of the person with disability or others.⁶²⁹*

6.130 Furthermore, ‘the person with disability to whom the behaviour support plan applies must be given opportunities to participate in community activities and develop new skills that have the potential to reduce or eliminate the need for regulated restrictive practices in the future’.⁶³⁰

6.131 It is important that the Disability Royal Commission interrogate gendered ableism in the development of and content of behaviour support plans related to LARC. This interrogation should consider: what the specific behaviour of concern is, why LARC is considered necessary as opposed to other strategies, what supports are identified to develop skills to end use of LARC, what is the timeframe for provision of these supports and cessation of the LARC (and why these supports cannot be immediately implemented in order to avoid the use of LARC in the first place). The importance of such exploration is underscored by a review of 23 behaviour support plans in a study by the Victorian Senior Practitioner in relation to menstrual suppression which found a lack of specificity in relation to the purpose and timeframes for use of LARC as a restrictive practice:

Reported themes of menstrual suppression use in the BSPs were:

- *to reduce distress or anxiety*
- *to reduce hygiene risk*
- *to address behaviours of concern related to menstruation*
- *to address pain or feeling unwell*
- *by choice of the person*
- *for contraception.*

Though some uses of menstrual suppression were reported to be for the purpose of managing behaviours of concern (i.e. risk of harm to self or others), many were reported for other reasons (such as choice, distress or contraception), or no information was provided for purpose.⁶³¹

6.132 Moreover, five of the BSPs did not even comply with the *Victorian Disability Service Act* requirements in relation to BSPs, which included requirements to provide details:

- Evidence is provided of physical harm to the person or another person.
- Evidence is provided of physical harm to the person or another person from property destruction.
- An explanation is provided of how the restraint or seclusion is used for behaviour support.
- An explanation is provided as to how the restraint or seclusion will be of benefit to the person.
- A demonstration is provided as to how the restraint or seclusion is least restrictive of the person as is possible in the circumstances.⁶³²

6.133 The report found that five of the reports were non-compliant:

Five of the BSPs were identified as being non-compliant with legislation. All five that were non-compliant did not demonstrate how the restraint or seclusion is least restrictive of the person as is possible in the circumstances. One BSP was non-compliant with the first five points as listed above, as there was no behaviour of concern identified.⁶³³

6.134 The Victorian Senior Practitioner report found that of the 82 women subject to menstrual-related restrictive practices, 9 had been subject to the restrictive practice for 11 years (the entirety of the study period, and possibly further back in time prior to the data collection) and 44 for 5-11 years.⁶³⁴

6.135 Interrogation of Behaviour Support Plans is also important because ‘menstrual care’ is recognised by the National Disability Insurance Agency (NDIA) as an aspect of ‘personal care supports’ (i.e., ‘assistance with daily personal activities including assistance with, or supervision of, personal tasks of daily life’ that can be funded).⁶³⁵ In relation to children the NDIA website states:

Personal care supports for children are not intended to replace the usual care and supervision provided, or paid for, by a parent (see does the funding of the support take into account what is reasonable to expect others to provide ?). However, the

NDIA may fund personal care supports for children with complex needs where the level of support needed is beyond the level usually required for children of the same age.

A participant's request that intimate personal care not be provided by family members or friends should always be respected and taken into account when determining the level of assistance that should be funded.

Supports to provide assistance with daily personal activities should generally be limited to a maximum of 6 hours per day. This level of support is based on:

** bathing, dressing, toileting and grooming up to 2 hours per day including bowel management, skin care, bladder management, menstrual care...⁶³⁶*

If NDIA will fund menstrual care, then it is unclear why disability services would use forced menstrual suppression in lieu of menstrual care. It is also unclear if there is any scrutiny of whether disability services are being funded to provide menstrual care in relation to particular women or girls, at the same time that these women or girls have been put on LARC. WWDA is concerned that non-consensual LARC is being used for organisational convenience of service providers and staff (e.g., to avoid staff discomfort from having to deal with menstrual blood) and for organisational efficiency (e.g., to reduce labour costs involved in personal care and to avoid labour costs of staff supporting women to learn about menstruation).

It is also important to note that the NDISQSC guidance on LARC discussed above focuses on menstruation and there is nothing to indicate that LARC can be used non-consensually in NDIS funded services – either as medical treatment or chemical restraint – specifically in response to behaviour related to sexual activity or to prevent pregnancy. However, WWDA is aware of LARC being used non-consensually in relation to women with disability because they are sexually active, including in the context of sexual activity that is exploitative and abusive for the women. And, the report by the Victorian Senior Practitioner discussed earlier also indicated LARC being used as contraception. WWDA is concerned that LARC is being used for reasons of organisational convenience and efficiency to save on labour costs associated with supporting women to develop a positive sexuality and positive intimate relationships. WWDA is also concerned LARC is being used for reasons of organisational risk management, as contraception to avoid the risk of pregnancy including from sexual assault or from unsafe sex which women are exposed to due to the service's failure to provide support for safe and positive sexual activity. This is an important issue for the Royal Commission to explore, particularly because of the possibility that non-consensual LARC might be used for economic-efficiency reasons to avoid more resource-intensive and trauma-informed approaches to supporting women with disability's development of a positive sexuality and ensure their safety from sexual violence. In a similar vein, it is important the Royal Commission explore use of LARC in relation to girls in out of home care settings, where similar issues might arise about tensions between convenience, safety, development of positive sexuality and trauma-informed support.

- 6.136 It is unclear whether there are any effective lines of accountability and redress to respond to these serious concerns about reproductive violence against women and girls with disability in NDIS services through use of non-consensual LARC. The oversight of LARC in NDIS funded disability services is more directed towards regulation of violence rather than accountability and redress. The NDISQSC was established by s 181A of the *National Disability Insurance Scheme Act 2013* (Cth) and assists the National Disability Insurance Scheme Quality and Safeguarding Commissioner in their functions.⁶³⁷ The Commissioner's core functions include: 'uphold[ing] the rights of, and promote the health, safety and wellbeing of, people with disability receiving supports or services, including those received under the National Disability Insurance Scheme'; 'develop[ing] a nationally consistent

approach to managing quality and safeguards for people with disability receiving supports or services, including those received under the National Disability Insurance Scheme'; 'secur[ing] compliance with this Act through effective compliance and enforcement arrangements'; and 'promot[ing] continuous improvement amongst NDIS providers and the delivery of progressively higher standards of supports and services to people with disability.'⁶³⁸ The Commissioner's functions also include: 'provid[ing] leadership in relation to behaviour support, and in the reduction and elimination of the use of restrictive practices, by NDIS providers' ('behaviour support function');⁶³⁹ investigate and resolve complaints ('complaints function');⁶⁴⁰ and monitor compliance with conditions of registration ('registration and reportable incidents function').⁶⁴¹

- 6.137 The NDISQSC is framed as the core solution to addressing the use of restrictive practices in disability services. Yet, its functions are clearly contradictory in terms of protecting people with disability from the violence of restrictive practices – upholding rights of people with disability at the same time as enabling restrictive practices, enabling restrictive practices at the same time as resolving complaints about their use – and this shows that one of the core (albeit unwritten) functions of NDISQSC is to regulate violence against people with disability through restrictive practices. Moreover, the NDISQSC's 'behaviour support function' gives rise to an individualised and beneficial understanding of restrictive practices as being to help specific individuals in response to their behaviour within a macro context of reducing the overall use of restrictive practices, at the same time that the NDISQSC is responsible for monitoring the use of restrictive practices.
- 6.138 The role of NDISQSC in enabling violence through restrictive practices is also supported by its management of reportable incidents under its registration and reportable incidents function. 'Reportable incident' is defined as: 'the death of a person with disability'; 'serious injury of a person with disability'; 'abuse or neglect of a person with disability'; 'unlawful sexual or physical contact with, or assault of, a person with disability'; 'sexual misconduct committed against, or in the presence of, a person with disability, including grooming of the person for sexual activity'; and 'use of a restrictive practice in relation to a person with disability, other than where the use is in accordance with an authorisation (however described) of a State or Territory in relation to the person.'⁶⁴² It is striking that each form of reportable incident is not qualified by the authorisation of its perpetration with the exception of restrictive practices. This gives rise to a situation where women and girls with disability who are subject to reproductive violence through authorised chemical restraints are subject to a lower threshold of access to justice and protection from violence, than those who experience other forms of violence, abuse, neglect and exploitation that are recognised as reportable incidents.
- 6.139 While unauthorised restrictive practices are technically not allowed, in practice they are implicitly permissible because there is a high number of unauthorised restrictive practices that are reported and NDISQSC does not automatically take regulatory action against the NDIS providers involved in these incidents. For example, in relation to 'reportable incidents', the NDISQSC has no legislated role in reporting incidents to police, although NDIS providers have an obligation to notify the NDISQSC within a short timeframe whether their response to the incident included reporting to police.⁶⁴³ Furthermore, there is an absence in the National Disability Insurance Scheme Act 2013 (Cth) of options for redress for victims subject to unauthorised restrictive practices. In the NDIS legislative framework, restrictive practices are either permitted de jure or de facto.
- 6.140 The regulation by the NDISQSC of violence perpetrated through forced contraception and menstrual suppression is part of a broader tension in the NDIS between its focus on choice and control and human rights, and its silence and inaction on violence, as Frohmader and Sands note:

The National Disability Insurance Scheme (NDIS) Act 2013 is a pertinent example of how Governments may be unintentionally complicit in rendering crimes of violence against people with disability in institutional and residential settings invisible, and/or minimised. The objects of the NDIS Act 2013, amongst other things, are to “give effect to Australia’s obligations under the Convention on the Rights of Persons with Disabilities” and to give effect to Australia’s obligations under the other international human rights treaties to which it is a party. The NDIS Act contains General Principles guiding all actions under the Act, and includes a specific principle drawn from CRPD Article 16, stating that “people with disability have the same right as other members of Australian society to respect for their worth and dignity and to live free from abuse, neglect and exploitation”. Article 16 of the CRPD however, indicates that States Parties “shall take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects”. Omission of the word ‘violence’ from the principles of the NDIS Act may seem, on face value, relatively inconsequential. However, as previously highlighted, the use of the term ‘abuse’ instead of ‘violence’ serves to minimise the severity of crimes perpetrated against people with disability; can be used to deliberately de-criminalise or trivialise serious offences, and results in poor or inappropriate service responses. In this context, it remains unlikely that the NDIS Act 2013 can provide access to effective protection for people with disability experiencing violence in institutional and residential settings.⁶⁴⁴

- 6.141 It is unclear how regulation of LARC as a chemical restraint achieves objects of choice and control and gives effect to Australia’s obligations under the CRPD.⁶⁴⁵ The use of LARC in NDIS funded disability services exemplifies the slow violence and economic violence⁶⁴⁶ inherent to sexual and reproductive violence against women and girls with disability. WWDA is concerned that it is possible that, at a structural and organisational level, reproductive violence through non-consensual LARC is factored into how services operate and are financially sustainable and profitable. Yet, these restrictive practices are used with such regularity and banality in the everyday delivery of services and for such long periods of time that they can be difficult to isolate as specific acts of violence. WWDA urges the Royal Commission to interrogate how cultural ideas about menstruation and sexuality of women and girls with disability coupled with the economic, neoliberal framework of the NDIS and disability service provision drive reproductive violence against women and girls with disability through NDIS service provision. The Royal Commission is urged to carefully consider how use of chemical restraint in response to their menstruation and sexual activity demonstrates how the disability support needs of women and girls with disability become a source of economic extraction for disability service providers and thus reflect how their bodies and lives do not matter.



Guardianship Law and Authorisation of Forced Contraception and Menstrual Suppression

6.142 While NDIS legislation authorises NDIS funded services to use LARC as a restrictive practice within NDIS funded services, as a non-consensual intervention that could amount to criminal or civil assault, LARC also needs to be authorised under guardianship legislation in order to legally authorise the individuals administering the LARC. In contrast to the specific provisions for authorisation of sterilisation under guardianship law (discussed earlier), the authorisation of LARC under guardianship law is more dispersed and complex. LARC can be authorised as medical treatment or restrictive practice, depending on its purpose. In relation to the former, in many jurisdictions there is legal recognition of the authority of third parties close to the individual (ranging in a hierarchy from guardians to spouse, primary carer, family member and friends) to consent whenever the need for consent arises without requiring tribunal authorisation or formal appointment of a guardian, whereas the latter is consented to by a guardian (who must have the restrictive practices function) and generally also requires a Behaviour Support Plan. This division in guardianship authorisation of non-consensual LARC tracks onto the recurring and troubling binary of therapeutic and non-therapeutic which is present in family law authorisation of sterilisation and NDIS regulation of use of LARC in NDIS-funded services.

6.143 In relation to authorisation of LARC as medical treatment, there is much variation between jurisdictions. In New South Wales, ‘major treatment’ is defined as including:

any treatment that involves the administration of a long-acting injectable hormonal substance for the purpose of contraception or menstrual regulation,

Note: An example of such a substance is medroxyprogesterone acetate, in suspension, commonly known as Depo-Provera.

any treatment that involves the administration of a general anaesthetic or other sedation ...

any treatment used for the purpose of eliminating menstruation.⁶⁴⁷

6.144 Major treatment can be consented to by NCAT or the ‘person responsible for the patient’⁶⁴⁸ which is the guardian (if one is appointed for medical treatment decisions) or otherwise someone else close to the person such as a parent or partner (according to a legislative hierarchy).⁶⁴⁹ However, forms of contraception which are not injectable, such as the contraceptive pill, would sit outside the definition of ‘major treatment’ and can be consented to by NCAT or the ‘person responsible for the patient’,⁶⁵⁰ or even be administered without any such consent if ‘there is no person responsible for the patient’ or ‘there is such a person but that person either cannot be contacted or is unable or unwilling to make a decision concerning a request for that person’s consent to the carrying out of the treatment’ and the doctor certifies ‘the treatment is necessary and is the form of treatment that will most successfully promote the patient’s health and well-being’ and ‘the patient does not object to the carrying out of the treatment’.⁶⁵¹

6.145 In the Northern Territory, guardians can be appointed to make decisions in relation to ‘health care action’ which ‘for an adult, means commencing, continuing, withholding or withdrawing health care for the adult’.⁶⁵²

6.146 In the Australian Capital Territory ‘a medical procedure concerned with contraception’ is categorised as a ‘prescribed medical procedure’ requiring ACAT consent where it is otherwise lawful and ‘the procedure would be in the person’s best interests’.⁶⁵³ In deciding whether a particular procedure would be in the person’s best interests, ACAT must take

into account factors including ‘the wishes of the person, so far as they can be ascertained’, ‘what would happen if it were not carried out’ and ‘what alternative treatments are available’.⁶⁵⁴ However, presumably oral contraception (that does not involve a procedure to administer) would not fall within this definition and would instead be within general scope of guardian⁶⁵⁵ or informal ‘health attorney’⁶⁵⁶ consent to medical treatment.

- 6.147 In Queensland, a guardian will have power to consent to a health matter which is defined as ‘a matter relating to health care, other than special health care, of the adult’.⁶⁵⁷ A health matter includes contraception and menstrual suppression as these do not come within the scope of ‘special health matter’⁶⁵⁸ which requires specific tribunal consent. This power is by reason of the guardians authorisation to do ‘anything in relation to a personal matter that the adult could have done if the adult had capacity for the matter when the power is exercised’.⁶⁵⁹ This provision would then be interpreted by reference to the *Guardianship and Administration Act 2000 (Qld)*’s general principles and health care principles,⁶⁶⁰ including considering: ‘the consequences for the adult if the proposed health care is not carried out’, ‘the benefits versus the burdens of the proposed health care’, and ‘the effect of the proposed health care on the adult’s dignity and autonomy’.⁶⁶¹
- 6.148 In South Australia, ‘medical treatment’ is defined as ‘the provision by a medical practitioner of physical, surgical or psychological therapy to a person (including the provision of such therapy for the purposes of preventing disease, restoring or replacing bodily function in the face of disease or injury or improving comfort and quality of life) and includes the prescription or supply of drugs’.⁶⁶² This is quite a broad definition which would include a range of contraception and menstrual suppression – implanted/inserted and oral. Consent to medical treatment is through the guardian or (if no guardian) the person responsible.⁶⁶³
- 6.149 Similarly, in Tasmania, ‘medical treatment’ is defined as: ‘medical treatment (including any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care) normally carried out by, or under, the supervision of a medical practitioner’.⁶⁶⁴ A guardian or (if no guardian) the other personal responsible can consent to medical treatment.⁶⁶⁵
- 6.150 In Western Australia, a plenary guardian’s functions include ‘mak[ing] treatment decisions for the represented person’.⁶⁶⁶ A limited guardian can make treatment decisions where they have been given this function.⁶⁶⁷ ‘Treatment’ is defined as including ‘medical or surgical treatment, including a life sustaining measure or palliative care’.⁶⁶⁸
- 6.151 In Victoria, guardians can make decisions about a ‘medical treatment decision’, which is defined as ‘a decision to consent to or refuse the commencement or continuation of medical treatment or a medical research procedure’.⁶⁶⁹ ‘Medical treatment’ is defined as: ‘any of the following treatments of a person by a health practitioner for the purposes of diagnosing a physical or mental condition, preventing disease, restoring or replacing bodily function in the face of disease or injury or improving comfort and quality of life—(a) treatment with physical or surgical therapy; (b) treatment for mental illness; (c) treatment with prescription pharmaceuticals; (d) dental treatment; (e) palliative care—but does not include a medical research procedure’.⁶⁷⁰ If a guardian is not appointed, a decision can instead be made by the relevant ‘medical treatment decision maker’ (e.g, spouse or primary carer).⁶⁷¹
- 6.152 This survey of legal authorisation of LARC as medical treatment demonstrates the much lower legal threshold and tribunal oversight under guardianship law for authorisation of reproductive violence of non-consensual LARC as compared to sterilisation, and this is particularly so in relation to oral contraceptive pill where there is some ambiguity in some jurisdictions about what level of authorisation if any is required.

- 6.153 In contrast to legal authorisation under guardianship law of LARC as medical treatment, the legal authorisation of LARC as restrictive practice (as is required in some instances in relation to NDIS funded disability services) is subject to a higher legal threshold (albeit still lower than for sterilisation). Generally, it requires appointment of a guardian, the guardian needs to be given a decision-making function related to restrictive practices, and then the guardian can only consent to restrictive practices where there is a Behaviour Support Plan in place in relation to the specific restrictive practices. Some of our concerns with restrictive practices were raised earlier in the context of the NDIS, and in WWDA's Royal Commission Submission on Restrictive Practices.
- 6.154 Nevertheless, what is apparent across LARC's legal authorisation as medical treatment or as restrictive practice is the key role of guardians. While some women and girls with disability might have a family member or close friend as their guardian, women and girls who do not have access to a guardian from their own networks (e.g., because they are socially isolated or who have been in out of home care as a child) will be appointed the Public Guardian. The Public Guardian has high caseloads and does not have ongoing and meaningful involvement with the represented person. The National Standards of Public Guardianship specify that guardianship staff making legal decisions 'will endeavour to meet in person or use audio-visual technology to have direct contact with the represented person at least once a year'.⁶⁷² A meeting, potentially not even face-to-face, once a year is not sufficient opportunity to develop a deep knowledge and understanding of a person's circumstances and develop a strong connection with the person, so as to then be consenting to such significant interventions in their bodies related to such personal and intimate matters as menstruation, reproduction and sexuality.

Neglect, Deception and Coercion in LARC Decision-Making by Women and Girls with Disability

- 6.155 LARC can also occur outside of the legal frameworks discussed above. Some women and girls with disability do request and consent to LARC, and their opportunity to access and make decisions about contraception should be supported. However, there are issues of neglect, deception and coercion in terms of the decision-making and this is particularly apparent for women and girls with intellectual disability.
- 6.156 First, women and girls with disability who want to access LARC for contraception purposes might be denied the opportunity to access and consent to LARC. This is because their sexually activity or intimate relationship are viewed unfavourably by disability service providers or family members. Guardianship orders might be used to limit their opportunities for sexual activity or intimate relationships (e.g. through physical or environmental restraint or limiting who they socialise with). Or, disability service providers and family members might informally do this, such as changing the woman's residence or modifying her social and community involvement.
- 6.157 Second, WWDACT have raised concern that doctors do not know of guardianship law requirements concerning LARC:

*some of the doctors in the ACT are not aware about the procedures for granting contraception to women/girls with LD. WWDACT has anecdotal evidence in the ACT that the trend might not be different in Australia. In one case, a young woman with disabilities sought and underwent an implant operation without going through the ACAT process.*⁶⁷³

- 6.158 Third, as noted by WWDACT women with disability might not be provided with sufficient and accessible information to support their decision-making and informed consent:

women with disabilities face attitudinal barriers with doctors. They feel treated like children and like “a disability” rather than a human being. The women interviewed also reported that they were treated as asexual beings and therefore very little information of contraception was delivered to them. ...

Further, it appears that some medical professionals do not include women with LD in the decision-making process assuming that they cannot comprehend it. This prejudice is a systemic issue. Women with LD are deprived of choosing for themselves and therefore lack training for making decisions. Hence, it makes it harder to reach an informed consent regarding contraception. ...

women with LD are usually not well informed about contraception or sometimes misinformed. For instance, emphasis is given to menstruation management and sexuality questions are avoided. ... little is known about contraceptive choices of women with high support needs. ...

Furthermore, women with disabilities lack access to sexual health offices like family planning to inform them on contraception and relationships.⁶⁷⁴

- 6.159 Fourth, women and girls with disability might also consent to LARC in circumstances of undue influence or coercion. This might operate at an individual level, such as when a parent or service provider pressures them into agreeing, or when a woman agrees to LARC to bolster her chances of her existing child/ren not being removed by child protection services.⁶⁷⁵ This coercion might also operate at a more structural and diffused level, such as the living conditions and power relations in institutional and segregated settings such as group homes, prisons and ADEs where women and girls with disability experience limited choice in many aspects of their life.

Denying Access to ART and Discrimination in Accessing ART

- 6.160 Women with disability experience difficulties accessing assisted reproductive technologies (ART), such as in vitro fertilisation (IVF). It has been noted that: ‘Many women with disability are deemed by fertility clinics as ineligible for assisted reproductive services.’⁶⁷⁶ WWDA notes that:

Women with disability experience significant discrimination in accessing assisted reproductive technologies (such as in-vitro fertilisation (IVF) and assisted insemination). Many women with disability - particularly single women with disability and women with disability in same-sex relationships - report being deemed by fertility consultants/clinics as ineligible for assisted reproductive services.⁶⁷⁷

- 6.161 Yet, this discrimination is also structurally embedded in law where regulation of ART services enables discrimination on the basis of disability:

In 2007, the Victorian Law Reform Commission (VLRC) released its final report on ART and adoption. The VLRC had been commissioned by the Victorian Government to enquire into and report on the desirability and feasibility of changes to the Infertility Treatment Act 1995 [Vic] and the Adoption Act 1984 [Vic] to expand eligibility criteria in respect of all or any forms of assisted reproduction and adoption. In relation to access to assisted reproductive technology, the VLRC decided:

“not to include impairment or disability as one of the grounds on which discrimination in relation to access to ART should be prohibited. This is because in some cases there is a nexus between disability and risk of harm to a child (for example, some forms of severe mental illness). Such a nexus does

not exist in relation to marital status or sexual orientation. This does not mean that people with a disability or impairment should be refused treatment, but that in some cases a different approach is justified. Such an approach should involve making enquiries about any potential risk to the health and wellbeing of a prospective child”.

The resulting amended legislation, renamed the Assisted Reproductive Treatment Bill 2008, omits disability from its non-discrimination clause: ‘persons seeking to undergo treatment procedures must not be discriminated against on the basis of their sexual orientation, marital status, race or religion’. In practice, this means that women with disabilities could be discriminated against on the basis of disability if seeking to access ART in Victoria.⁶⁷⁸

- 6.162 Although there is limited research on denial of access to ART by women and girls with disability in Australia, research from Canada indicates this is an issue in other jurisdictions.⁶⁷⁹

Non-consensual and Coercive Abortion

- 6.163 Women and girls with disability are subject to forced and coercive abortions.

- 6.164 As WWDA has previously noted

Prejudicial assumptions about the parenting capabilities of women with disability, particularly those with intellectual disability, and the misplaced assumption that there will be a risk that a child may be born with disability, puts significant pressure on women with disability to undergo abortion.⁶⁸⁰

- 6.165 For example, when visual artist, psychologist, academic and author Debra Keenahan who has achondroplasia dwarfism was pregnant, she was told by her gynaecologist she should have considered an abortion:

I actually didn’t mind if the child had dwarfism, because I never considered my physical disability being a ‘problem’. I always say that my dwarfism doesn’t disable me, what disables me are people’s attitudes to my dwarfism.

Unfortunately, this was illustrated when I attended my first appointment with the gynaecologist to whom my GP referred me. Apparently, this gynaecologist had experience working with dwarf mothers. After the cursory introductions, he read my doctors report: the ultrasound clearly established the foetus had achondroplasia. He looked at me and said matter-of-factly, ‘You should have come to me earlier. I could have done something about this.’ There was no doubt what that ‘something’ was.

I have since often wondered how he counselled other women who were pregnant with dwarf babies, or who were single mothers. Or was his concern only because I was the trifecta – a dwarf woman, pregnant with a dwarf child choosing to be a single parent?⁶⁸¹

- 6.166 Concerns around genetic transference of disability are also reflected in the examples of women and girls with disability being coerced by parents and health professionals to be sterilised, discussed earlier.

- 6.167 Even when health professionals do not raise specific concerns about genetic transference of a disabled woman’s disability to her baby, the conventional processes of prenatal testing and associated assumptions that parents only want ‘normal’ babies also constitute ableism that gives rise to ontological violence. Healthcare encounters where such comments are

made routinely or flippantly can have significant impact on the experiences of parents with disability, as noted by Jax Jacki Brown, a disability and LGBTIQ+ rights activist writer and educator, in the context of their experiences of IVF:

At the information night for prospective parents run by our clinic, a nurse told us about the genetic tests run on donor sperm. ... Discovering that part of the community to which I belong – a community I greatly value – was being screened out was really confronting and distressing. ...

So I told the nurse that we didn't want to be tested that we wouldn't be screening any embryos. I said, 'Disability is part of human variation.'

In response, she leant across the table and grabbed Anne's hand, looked her in the eye and said, 'But it's your choice, is that what you want?'

It was though she thought I had inappropriately influenced Anne's decision not to test for disability and she needed to let Anne know there was still time to make a different choice. I wondered, in that moment, what additional pressure the clinic would have applied to us to screen for disabilities had it been my body – my visibly disabled body – carrying our child. There is a fear of disabled people reproducing because we may create disabled children. ...The experience of disability, it is assumed, should be avoided, and that people with disabilities should feel ashamed of things that make them different.⁶⁸²

6.168 Jax Jacki Brown continued to have such experiences into their partner's pregnancy:

After the [10 week] scan our obstetrician said she's noticed on our file that we hadn't yet had any of the genetic screening tests and she wanted to assure us that it wasn't too late to screen for a variety of disabilities. She pushed a pamphlet across the desk at us. It outlined all the conditions they can screen for – Down syndrome, spinal muscular dystrophy, cystic fibrosis.

'Do you know what these conditions are?' she asked.

'Yes,' I replied. 'Some of my friends have them.'

The obstetrician asked, 'Are they still alive?'

'Yep,' I responded, 'they live full and happy lives actually.' ...

Even in the delivery room when Anne was in labour, the midwife asked us – after reading our file – why we hadn't screened for Down syndrome. This ongoing pressure on us to justify our choices was exhausting and it also brought into focus ingrained assumptions about disability and the assumed worth of people with disabilities ...⁶⁸³

6.169 Moreover, at times women with disability might have undergone termination of wanted pregnancies because of a lack of financial and social supports.⁶⁸⁴

6.170 Women who do voluntarily seek abortions might not be provided with the same level of support due to assumptions that abortion is the necessary consequence of a woman with disability being pregnant and that women and girls with disability do not experience the full range of emotional and physical impacts of abortion. This is explained by disability activist Nic Lee's experience of undergoing an abortion:

I was about 22 when I attended a clinic for a termination. I already had one child, so this was a difficult decision. I expected to be offered counselling and treated with empathy and concern. But oddly, no one blinked an eye. No counselling. No

questions. Further to this, no support was offered afterward.

As a disabled woman, to the outside world my choice to end a pregnancy was seen unquestionably as the “right” decision. This view potentially stems from fears around passing on genetic disorders. It’s a fear that has its origins deeply rooted in eugenics, and what is subjectively deemed as whether or not a disabled person can live “a good life.” Or it could have come from the unwittingly negative views that surround our bodies, and our ability to adapt or cope with motherhood. In other words: People seem to think that being pregnant was going to be too hard for me. I still don’t understand why this would negate the need for support, and at the time I felt alone and confused; I honestly couldn’t process this reasoning completely.

However, I reflect back on it now and realise how vastly unsupported I was in contrast to other non-disabled women at the clinic. My abortion was viewed as uncomplicated and unemotional in comparison to others. I felt like I didn’t matter—that my choice wasn’t just as difficult as the other women around me. No kind words from the nurses, no checking in to see how I was coping. Nothing. Silence.

When you live in a world that dismisses the sexuality and sexual needs of disabled people, the way I was treated shouldn’t have been a surprise to me.⁶⁸⁵

Legal Authorisation of Abortion

- 6.171 Women and girls with disability can be subjected to abortion without their consent. Non-consensual abortion can be legally authorised pursuant to Supreme Courts, guardianship tribunals, some mental health tribunals and children’s courts.
- 6.172 Similar to sterilisation, not all legal matters involving applications for abortion are publicly available. However, the following cases were found via searching Australian case citator databases.

	Decision	Court/Tribunal	Outcome
NSW	<i>Re a Patient Fay</i> [2016] NSWSC 624	Supreme Court	Abortion authorised
	<i>Re DXI</i> [2016] NSWCATGD 4	NCAT	Abortion not authorised
QLD	<i>GRC</i> [2016] QCAT 268	QCAT	Abortion not authorised
	<i>QDB</i> [2017] QCAT	QCAT	Abortion not authorised

- 6.173 Turning to guardianship law, similar to the discussion of sterilisation earlier, tribunal authorisation is required for abortion.
- 6.174 Guardianship law in a number of jurisdictions – New South Wales, Australian Capital Territory – use a ‘best interests’ test. In New South Wales, similar to sterilisation, ‘any treatment that is carried out for the purpose of terminating pregnancy’ falls within the category of ‘special treatment’.⁶⁸⁶ Special treatment can only take place pursuant to NCAT authorisation. However, unlike in the context of sterilisation which is focused on medical necessity, there is a lower threshold test of ‘best interests’. NCAT ‘may give consent to the carrying out of the treatment if it is satisfied that: ‘the treatment is the only or most appropriate way of treating the patient and is manifestly in the best interests of the patient’.⁶⁸⁷ NCAT must also be satisfied that ‘the treatment is the most appropriate form of treatment for promoting and maintaining the patient’s health and well-being’.⁶⁸⁸

- 6.175 In the Australian Capital Territory, ‘abortion’ is categorised as a ‘prescribed medical procedure’ requiring ACAT consent where it is otherwise lawful and ‘the procedure would be in the person’s best interests’.⁶⁸⁹ In deciding whether a particular procedure would be in the person’s best interests, ACAT must take into account factors including ‘the wishes of the person, so far as they can be ascertained’, ‘what would happen if it were not carried out’ and ‘what alternative treatments are available’.⁶⁹⁰ Similarly, in Tasmania, ‘termination of pregnancy’ is a ‘special medical treatment’ which must be consented to by the TASGAB, and such consent can be given where the procedure is otherwise lawful and it would be in the ‘best interests’ of the person.⁶⁹¹ Similar to the ACT, in determining best interests, the TASGAB can consider a variety of factors including ‘the wishes of that person, so far as they can be ascertained’, ‘the consequences to that person if the proposed treatment is not carried out’, and ‘any alternative treatment available to that person’.⁶⁹²
- 6.176 In Western Australia, a plenary guardian’s functions include ‘mak[ing] treatment decisions for the represented person’.⁶⁹³ A limited guardian can consent to abortion where they have been given the medical treatment function.⁶⁹⁴ In exercising this function, the ‘guardian shall act according to his opinion of the best interests of the represented person’.⁶⁹⁵
- 6.177 In contrast to the jurisdictions that focus on ‘best interests’, the Queensland legislation is vague, providing that: ‘The tribunal may consent, for an adult with impaired capacity for the special health matter concerned, to termination of the adult’s pregnancy only if the tribunal is satisfied the termination may be performed by a medical practitioner under the *Termination of Pregnancy Act 2018*’. This provision would then be interpreted by reference to the general principles of the *Guardianship and Administration Act 2000* (Qld), including ‘same human rights’, ‘individual value’, ‘valued member of society’,⁶⁹⁶ and health care principle ‘means power for a health matter, or special health matter, for an adult should be exercised by a guardian, the public guardian, the tribunal, or for a matter relating to prescribed special health care, another entity—(a) in the way least restrictive of the adult’s rights; and (b) only if the exercise of power—(i) is necessary and appropriate to maintain or promote the adult’s health or wellbeing; or (ii) is, in all the circumstances, in the adult’s best interests’.⁶⁹⁷
- 6.178 In South Australia, ‘termination of pregnancy’ is a ‘prescribed treatment’ that can be authorised by the SACAT⁶⁹⁸ where the termination would otherwise not be a criminal offence and ‘there is no likelihood of the woman acquiring the capacity to give an effective consent within the period that is reasonably available for the safe carrying out of the termination’ and the SACAT ‘has no knowledge of any refusal on the part of the woman to consent to the termination, being a refusal that was made while capable of giving effective consent and that was communicated by her to a medical practitioner’.⁶⁹⁹
- 6.179 In Victoria, VCAT can consent to ‘termination of pregnancy’ as a ‘special medical procedure’⁷⁰⁰ but instead of best interests the question is whether ‘the patient would consent to the carrying out of the special medical procedure if the patient had decision-making capacity in relation to giving consent’ and if the individual has not expressed their preferences then ‘VCAT must give consideration to the patient’s values whether— (i) expressed other than by way of a values directive; or (ii) inferred from the patient’s life’.⁷⁰¹ If VCAT cannot take this approach ‘because it is not possible to ascertain or apply the patient’s preferences or values’ then VCAT can consent to termination of pregnancy after if satisfied that it ‘will promote the personal and social wellbeing of the patient, having regard to the need to respect the patient’s individuality’ and has considered ‘likely effects and consequences’ of the termination and ‘whether there are any alternatives, including refusing the special medical procedure, that would better promote the patient’s personal and social wellbeing’.⁷⁰²

- 6.180 Under NSW mental health legislation, forced abortion is permissible in relation to involuntary patients in an emergency (even if the woman does not lack capacity) if ‘it is necessary, as a matter of urgency, to perform a surgical operation on the patient in order to save the patient’s life or to prevent serious damage to the patient’s health or to prevent the patient from suffering or continuing to suffer significant pain or distress’⁷⁰³ or is permissible upon Mental Health Review Tribunal authorisation on the basis the individual lacks capacity and the surgery ‘is desirable, having regard to the interests of the patient, to perform the surgical operation on the patient’.⁷⁰⁴ In contrast, Tasmanian legislation explicitly excludes ‘a termination of pregnancy’ and ‘a procedure that could render a person permanently infertile’ from the treatments under the Act.⁷⁰⁵
- 6.181 As we noted in Section 2, recent reforms decriminalising consensual abortion in crimes legislation has failed to address the continued legality of non-consensual abortion pursuant to common law doctrine of *parens patriae* and the various legislative provisions identified above. Indeed, we showed in Section 2 that some law reform inquiries considering decriminalisation of abortion has cursorily and explicitly stated the appropriateness of existing guardianship laws related to abortion.
- 6.182 Following its review of Australia in 2019, the UN CRPD Committee expressed its “serious concern” at the ‘*ongoing practice of forced sterilization, forced abortion and forced contraception of persons with disabilities, particularly women and girls, without their free and informed consent, which remains legal*’. The Committee also expressed its concern regarding the ‘*discrimination, particularly of women with disabilities and LGBTIQ+ persons with disabilities in accessing assisted reproductive technologies*’. In its Concluding Observations to Australia following the 2019 review, in relation to these issues, the CRPD Committee recommended, that Australia:
- adopt uniform legislation prohibiting, in the absence of free and informed consent, the sterilization of adults and children, the administration of contraception and abortion procedures on women and girls with disability;
 - ensure that women with disabilities and LGBTIQ+ persons with disabilities have equal access to assisted reproductive technologies.

Sexual Identity, Expression and Activity

- 6.183 Women and girls with disability can experience violence related to sexual identity, expression and activity. This violence takes a variety of forms: unwanted sexual harassment and violence, interventions to physically prevent expressions of sexuality, and denial of support, resources and information to support positive sexual identity and activity.
- 6.184 Women with disabilities have spoken about the impact of these violations related to sexual identity, expression and activity:

“In (my institution) you were not allowed to be with a man. You got into trouble. It’s not right.”

“Persons who reside in institutions are being denied their basic human rights to freedom, privacy and sexuality.”

“I’m not allowed to have a boyfriend.”

“We want information about relationships and having babies.”

“Jean lived in the dormitory next door to mine. She was going with her boyfriend,

Simon, who lived in a separate part of the same institution and was sometimes permitted to go across the courtyard to visit him. One day, they were caught petting in a seldom-used back room and they were forbidden to see each other thereafter. They were both over the legal age of consent and were doing nothing wrong by normal social standard.”

“If you go in a group home that’s run by like, a religious organisation, you’re not allowed to have a boy come over. You’re not allowed to even kiss a boy let alone have sex. If you wanted to have sex you would have to go maybe to the park or somewhere.”

“Sexuality is not just sexual intercourse. It is much, much more than just the physical act of having sex. Our sexuality is as much a part of us as our clothes-sense, our favourite foods and our personal style. Our need to love and be loved is as vital to our wellbeing as our need to eat, drink and breathe. To deny our sexuality is to deny that we are whole human beings.”

“Sexuality within institutional accommodation should not even be an issue. Privacy and freedom are not privileges to be granted or taken away. They are our basic human rights. Just as people who run the institutions would not appreciate their own sex life to be regulated by a stranger, nor do we. What we do in our own rooms, and who we do it with, is not the business of staff, administration, the milkman, or anyone else.”⁷⁰⁶

6.185 Violence that prevents the development and exercise of sexual identity, expression and activity constitutes epistemic violence in denying to women and girls with disability the opportunity to define their own identities and pursue their sexual desires as they define them. In turn these particular forms of violence are also ontological violence in denying to women and girls with disability the status of full sexual subjects and agents. Denial of support, resources and information to support sexual expression and activity also gives rise to economic violence on the basis that sexual needs of women and girls with disability are not considered worthy of public resources and disability service provider resources and labour.

6.186 Denial of support, resources and information to support sexual expression and activity can also contribute to the conditions that expose women and girls with disability to sexual violence. This is noted by Noonan and Gomez Taylor who explain:

People with intellectual disability have rights to sexual expression and information about bodies and sex. The need to protect people from sexual abuse and exploitation, therefore, has to be balanced with the need to protect people’s other sexual rights, such as the right to information. The two aims go hand in hand, as information and language about sex can help empower people to say no or tell someone about abuse. With education, support and wider access to social situations, people with intellectual disability can live sexual lives.⁷⁰⁷

6.187 As WWDA has previously noted:

Women and girls with disability self-identify according to a range of sex, sexuality and gender identifications, but are often denied their fundamental right to express and explore these identities in ways that are meaningful to them. Their sexuality, gender identity and expressions are often heavily policed, denied or restricted - either directly or indirectly - by those in their lives, through attitudes or structural barriers.

Women and girls with disability who are also people of colour or members of minority groups or indigenous peoples, or who are gay, lesbian, transgender, non-binary, gender diverse or intersex or who live in poverty, or who are incarcerated

in institutions, are subject to denial of their sexual and reproductive rights and particularised forms of violence and discrimination.

Women and girls with disability express desires for romantic, sexual and intimate relationships but report limited opportunities and difficulty negotiating relationships, often due to lack of support and paternalistic attitudes.

A central tenet to sexual and reproductive rights is individual choice – the right of all women to make informed choices about their bodies without bias and coercion. However, women and girls with disability are frequently excluded from participating in decisions that affect their lives on a daily basis, including as active agents in their own sexual and reproductive health care.

Prejudicial attitudes, values and stereotypes about the reproductive capacity of women with disability influence decisions taken about their sexual and reproductive rights. When these negative attitudes are combined with authority and power, they are a potent combination.

Girls with disability are often denied or limited in expressing their views in line with their evolving capacities, and are perceived as ‘fixed’ in their capacities to understand or participate in decision-making affecting their lives. Their decisions are routinely substituted by third parties, including families, guardians, legal representatives, and service providers.

Substitute decision-making and best interests approaches have been thoroughly criticised as fundamentally contravening the Convention on the Rights of Persons with Disabilities and as intrinsically value-laden. In practice, the best interests approach most often serves the interests of families, guardians and carers.

Attitudes toward women and girls with disabilities’ expression of their sexualities remain restrictive and laws against sexual exploitation are often interpreted as a prohibition of consensual relationships.

Health workers can be complicit in denying women and girls with disability their sexual and reproductive rights, and in perpetuating myths and negative stereotypes about women with disability. Many health workers lack knowledge of disability, hold inaccurate perceptions about women and girls with disability, and have a tendency to view women and girls with disability solely through the lens of their impairment/s.⁷⁰⁸

- 6.188 Women and girls with disability can be denied the opportunity to publicly express their sexuality, and their sexual expression can be punished or pathologised rather than validated as a human need, as is noted by Noonan and Taylor Gomez:

Social sanctioning of what constitutes acceptable behaviour for people with intellectual disability can be and historically has been oppressive. Public expressions of intimacy such as handholding and kissing are not considered acceptable for people with intellectual disability. ...

Sexually inappropriate behaviours are often seen as problems to be managed rather than genuine expressions of need, need for either information or for a relationship. For example, masturbation may be the only outlet for sexual expression for many people who have limited social opportunities to explore their own sexuality.⁷⁰⁹

- 6.189 In her ethnographic study of the lives of 21 women with disability living in a locked ward (within a large institution for people with intellectual disability), Kelley Johnston notes:

The lack of privacy within the unit ensured that all sexual expression was open to

surveillance by the staff. Masturbation or genital touching was not treated as sexual behaviour, but as an integral part of intellectual disability and as a 'dirty habit'. Women were reprimanded for this behaviour and told to stop it. They were not taught when and where it might be appropriate.....The sexuality of the women...was construed as a problem related to their intellectual disability which could be dealt with by isolating them from contact with others, containing their dangerousness and establishing strict measures of control over their behaviour...'⁷¹⁰

- 6.190 When women and girls' sexuality is recognised, it is often in a heteronormative framework, as noted by Noonan and Taylor Gomez in relation to people with intellectual disability:

Sexuality is an integral part of a person's adult life and often a part which is inaccessible or denied to adults with intellectual disability. Pervasive attitudes towards sexual expression by people with intellectual disability revolve around two assumptions—that the person is asexual or hypersexual OR if the person is sexual, then they are heterosexual, which is reported to be the dominant sexual identity in Australia.⁷¹¹

- 6.191 LGBTIQ+ people with disability have expressed the difficulties they experience in having their sexual identity recognised and respected, as demonstrated by the following narratives:

People living with a disability have likened revealing their disability as a second 'coming out', as Leslie, NSW, says: "I continually have to come out about my dyslexia and my digestive disorder- it's like a continual 'coming out'. I often feel like I have to fight the stigma of having a disability that I can't even broach the subject of my sexuality."⁷¹²

We don't come out once in our life; most of us come out every day, and I have to keep doing that around my sexuality, but also around my disability. My disability is very non-visual; it's in here, and it's the things that I can do and the things that I can't do... but it is difficult, in a workplace, to cover both of these things at once.⁷¹³

Well, for instance, I think often it's easier to be one or the other, and you don't often get to be both. You either get to be the person with a disability, and you don't always disclose, as others have said; or you get to be the gay person, but you don't get your disability side of you actually acknowledged, or sort of... I don't know. I think you often get split between the two, or between however many there are.⁷¹⁴

Two things that jump out most to me, in my experiences with disability and LGBTIQ+ communities is binarism in disability spaces, constant reminders that they don't acknowledge me and my identity, and I don't feel particularly welcome. And ableism in LGBTIQ+ spaces. I'm not often able to fully participate and feel comfortable in those spaces either, because they don't cater for my needs at all.⁷¹⁵

I think there's so many social barriers, in terms of people's ableism and negative attitudes around disability, within the broader community, but also within the LGBTIQ+ community... there's so many assumptions about people with disabilities, around our sexuality, our desire. Being viewed as not desirable or less than other people. You know, trying to find a relationship, but also trying to find a pash on a Saturday night is really hard.⁷¹⁶

- 6.192 LGBTIQ+ people with disability can experience discrimination from LGBTIQ+ and disability services, thus resulting in complex experiences of exclusion:

LGBTIQ+ people with disability may also experience ableist (disability-related) discrimination from within LGBTIQ+ services and communities and queerphobia

(LGBTIQ+-related discrimination) from within disability services and communities, compounding experiences of social marginality and isolation.⁷¹⁷

- 6.193 LGBTIQ+ organisations have discussed the difficulties surrounding the sexuality of LGBTIQ+ people with disability in institutional and residential settings. For example, the National LGBTIQ+ Alliance has stated that it has:

numerous reports about LGBTIQ+ people with disability labels and/or impairments in institutional and residential settings who were punished when staff misclassified everyday expressions of their sexuality, relationships, or gender to be ‘disruptive’ or ‘anti-social’. For example, an adult lesbian woman with an intellectual disability label who held hands with her girlfriend in view of staff was placed on a restricted status that limited her contact with visitors. This restrictive practice increased her social isolation.⁷¹⁸

- 6.194 Similarly, the Gay and Lesbian Rights Lobby has observed that:

Institutions are environments that pre-suppose resident passivity and asexuality. They are environments that are therefore virtually incapable of the formal acceptance of any form of resident sexual identity or expression, and certainly not homosexual love. Leslie, NSW, adds: “If organisations see someone with a disability, they automatically put that person in a disability box – it is almost like that person cannot have a sexuality.”⁷¹⁹

- 6.195 William Leonard and Rosemary Mann in their report on the everyday experiences of LGBTIQ+ people with disability note the difficulties encountered in accessing support for sexual expression:

Reduced social connection—including family, service providers and support groups, and mainstream, disability and LGBTI communities—are associated with reduced health and wellbeing for LGBTI people with disability. Conversely, positive and increased social connection across each of these areas is associated with improved health and wellbeing for LGBTI people with disability.

- *LGBT people with disability have difficulty connecting with LGBT communities and with disability communities*
- *LGBT people with disabilities have less freedom to express their sexuality or gender identity. This is even more so for LGB people with ID or LD*
- *Restrictions on freedom of sexual and gender diverse expression have consequences not only for the sexual health of LGBTI people with disability, but also on their ability to form social and intimate relationships and to connect to mainstream, LGBTI and disability support groups and communities*
- *Workers are often reluctant, unwilling or lack confidence in addressing the sexuality, sexual expression and gender diverse identities of LGBTI people with disability. Again, this lack of engagement is even more pronounced for LGBTI people with ID and creates barriers for accessing appropriate information, developing intimate and supportive relations, and connecting to LGBTI and disability community and support groups.⁷²⁰*

- 6.196 Women and girls with disability can be subjected to coercive and non-consensual interventions to prevent intimate relationships forming and developing. While the powers given to a person’s guardians might not extend to marriage,⁷²¹ divorce,⁷²² and entering into or ending de facto or sexual relationships,⁷²³ guardians can exercise control over some of the necessary circumstances to support the formation and development of

intimate relationships. Through their restrictive practices function, a guardian can consent to restrictive practices to physically detain or otherwise immobilise a woman in order to prevent her access to the community where she can meet and spend time with an intimate partner.⁷²⁴ Through their social access function, a guardian can decide who a woman with disability can or cannot visit, communicate with or have a relationship with.⁷²⁵ Through their accommodation function, a guardian can prevent a woman with disability from living with her intimate partner.⁷²⁶ If a guardian has a retrieval function, they have the authority to request a woman with disability be forcibly returned to her accommodation by police or ambulance services.⁷²⁷ Similar decisions about intimate relationships might be made informally through the decisions of disability service providers, family and carers. For example, disability services might also be empowered to move a woman or girl from their resident, away from a partner, if the woman is viewed as being at a safety risk, either as a legislative power⁷²⁸ or as a matter of their common law duty of care.

6.197 Disability can be a ground on which a marriage is void. Under the *Marriage Act 1961* (Cth) a marriage is void where ‘the consent of either of the parties was not a real consent because ... that party was mentally incapable of understanding the nature and effect of the marriage ceremony’.⁷²⁹

6.198 The Harmony Alliance found from consultations with its members and external stakeholders on family and domestic violence against CALD women with disability, that the focus protecting women from cultural practices can result in a failure to support autonomy of CALD women with disability in relation to marriage:

*The current approach also puts a higher emphasis on the issue of forced marriage of CALD women with disabilities, presenting it as a cultural problem. This approach often neglects the right to marry and form relationships that CALD women with disabilities find problematic.*⁷³⁰

Funding and Support for Sexual Expression and Pleasure

6.199 Women and girls with disability are viewed as asexual or hyper sexual, and as vulnerable to exploitation by others and in need of protection from others. For women with intellectual disability in particular, attitudes toward sexual expression remain restrictive and laws addressing sexual exploitation may be interpreted by others as meaning prohibition of women and girls with disability participating in intimate relationships.⁷³¹ This is demonstrated by two case studies:

Adult male and female residents of a group home run by a religious organisation, are prohibited from having any form of sexual or intimate relationships on the premises (either with each other or anyone else), as this is deemed to breach organisational policy and house rules. Although the residents are part of the local community and participate in activities outside the group home, they are prohibited from bringing a sexual or intimate partner to the home. Instead, the residents are told that if they want to have sex it has to occur off site. Several of the residents confirm that they have had sex in the local park, and the supermarket car park.

*A mother of a 24 year old woman with a mild intellectual disability seeks information as to whether she can get a restraining order against a man with an intellectual disability who has struck up a friendship with her daughter. She confirms that her daughter is happy in the man’s company and wants to spend more time with him. When asked why she wants to take out a restraining order against the young man, the mother advises that she doesn’t want her daughter to mix with him in case they want to have sex.*⁷³²

6.200 Women and girls with disability might be denied access to physical or other supports they require to enable them to develop positive sexuality. If they have experiences of gender-based violence they might need support with sexual activity that is not only accessible in relation to their disability but also trauma-informed and is physically and psychologically safe. Denying access to safe and positive opportunities for sexual activity can expose women and girls with disability to unsafe, exploitative and violent sexual encounters and relationships. While there is increasing recognition of the sexual support needs of people with disability, the public discussion has principally been on males with disability.

6.201 Women and girls with disability who live in disability residential settings can experience limited access to support for sexual activity and pleasure, as noted by Noonan and Taylor Gomez:

Due to life circumstances, many adults with intellectual disability live in supported accommodation or with their families. Because they may live in shared rooms or houses where staff members are working, there is a lack of privacy. Many people do not choose with whom they live, nor with whom they venture out into the community, nor their daily routine, daily activities or even clothes. People with intellectual disability have limited information about sexual behaviours and role models for sexual expression, and attitudes towards sexual expression by staff and family is usually highly prescriptive. Disability services generally have a lack of policy about facilitating sexual experiences for the people who use their services and support workers rarely receive training on sexuality. A person's physical and financial access to where people socialise is restricted and there is a clear omission of relationships and sexuality in life-planning processes. Further, the sexual needs of women and men with high support needs are largely ignored, resulting in a lack of developing friendships, exploring their own sensuality and the need for intimacy being ignored.

All these barriers derive from top to down service provision wherein the "decision maker" may determine the service structure and inadvertently or deliberately disallow the person with intellectual disability to experience and to make choices in relation to their own sexuality.⁷³³

6.202 The following case study by Family Planning NSW demonstrates the lack of appropriate response from disability service providers in supporting sexual activity and pleasure:

A woman, Olivia, in supported care, suffered repeated vaginal infections from masturbating with her hairbrush. These infections were treated with repeat prescriptions of antibiotics with no other efforts to understand the behaviour or support the person to adopt healthier behaviours. A support worker eventually supported Olivia to purchase a sex toy to minimize the risk of infection and lost their job as a result as this was considered inappropriate by the organization's management.⁷³⁴

6.203 Barriers to accessing supports related to sexual expression and activity have emerged in the context of the NDIS. Recent litigation considered whether the NDIS, as a universal scheme that funds 'reasonable and necessary' supports for Australians with permanent and significant disability, can fund sex therapy. In the Administrative Appeals Tribunal (AAT) matter of *WRMF and National Disability Insurance Agency* *WRMF and National Disability Insurance Agency*, the claimant (a female with multiple sclerosis aged in her forties) sought review by the AAT of a decision by NDIA rejecting her request for NDIS funding for a reasonable and necessary support in the form the services of a sexual therapist, specially trained in treating disabled persons.⁷³⁵ The NDIA submitted that this was neither 'a support, nor for a reasonable and necessary support contemplated or supported by the general principles of the Act applicant' including because she was 'seeking the services of a replacement sexual partner'.⁷³⁶

6.204 The Tribunal Member allowed the claimant's review, such that 'the reviewable decision will be set aside and the matter will be remitted for reconsideration with the direction that the support claimed, at the level claimed, is a reasonable and necessary support'.⁷³⁷ In the course of reaching this decision, the Tribunal Member stated that a core question is whether the requested support 'fulfil[s] a need of the participant? The word will extend to a health need, but is not limited to health needs'.⁷³⁸ The Tribunal Member was of the view that funding for the requested support would fall within s 14(a) of the Act,⁷³⁹ which provides that 'The Agency may provide assistance in the form of funding for persons or entities: (a) for the purposes of enabling those persons or entities to assist people with disability to: (i) realise their potential for physical, social, emotional and intellectual development and (ii) participate in social and economic life'.⁷⁴⁰ This was on the basis that:

*Her response to her achievement of sexual release (to the extent to which she is able to obtain such release) as a result of the services of a specialised sex therapist were described by the applicant in evidence which I accept as good for her mental wellbeing, her emotional wellbeing and her physical wellbeing at Transcript page 18, where she also said that her mood is less dull, it releases tension and anxiety, and improves her outlook on life.*⁷⁴¹

6.205 The Tribunal Member's view was also supported by themes arising from the objects and guiding principles of the NDIS Act 2013:

*Those themes are freedom of choice, the need (at least in some respects) to seek to place persons with a disability in a situation where they are not disadvantaged by comparison with those who do not have a disability, supporting persons with a disability to participate in and contribute to social and economic life to the extent of their capacity, maximising their independence, and their ability to make choices. The applicant chooses to have the services of a sexual therapist. Most people do not need such services to achieve sexual release, so in a sense she is put on a par with others as far as she can be. As I have found, the support will help her realise her potential for social and emotional development and to participate in social life.*⁷⁴²

The Tribunal Member noted that 'sexual release, to the extent to which she can manage it, and the generation of pleasure with the assistance of a sex therapist with disability training will assist her wellbeing'.⁷⁴³

6.206 This decision is a positive recognition of the importance of providing the financial support for disabled women to access the supports they need for sexual pleasure. However, there are three potential limitations to this decision. First, the Tribunal member drew a distinction between 'the services of a specially trained sex therapist' and 'the services of a sex worker',⁷⁴⁴ and noted that the question of 'whether the services of a sex worker can be a reasonable and necessary support for a disabled person' was beyond the scope of the review.⁷⁴⁵ The decision thus leaves open whether a sex worker could be funded, and risks limiting support to that which fits within a therapeutic or medicalised frame. Second, the Tribunal Member makes some observations of the claimant's intelligence, such as 'She has some psychiatric conditions which have evidently not affected her intellectual capacity, and she gave her evidence by telephone intelligently and it seemed to me, reliably'.⁷⁴⁶ It is unclear the reason for these observations, and the implications they might have for women seeking NDIS-funded sexual supports who have intellectual disability. This is particularly because the Tribunal Member also noted that the claimant 'is best placed to know the effects upon her of the sexual therapy she has received'.⁷⁴⁷ One would hope this recognition of autonomy would equally apply to a woman with intellectual disability. Third, in the course of considering the review, the Tribunal Member was of the view that the CRPD did not extend to 'sexual rights',⁷⁴⁸ although this did not impact on the member's ultimate decision to allow the claimant's review. This is concerning because

it takes a narrow approach to human rights which fails to consider many of the rights in the CRPD such as rights to equality, legal capacity, independent living and community inclusion, freedom of expression and privacy which provide the conditions in which sexual expression and pleasure can be enjoyed on an equal basis to others. Fourth, there is an unrecognised tension between this decision which supports disabled women's sexuality and the legality of NDIS funded disability services using non-consensual LARC (discussed earlier).

- 6.207 The NDIA appealed the AAT decision to the Federal Court, however this appeal was dismissed in the decision of *National Disability Insurance Agency v WRMF*.⁷⁴⁹ The Federal Court noted that sexual activity and sexual relationships would fit within s 24 of the NDIS Act 2013 which contains the threshold eligibility requirement of 'disability' in order to qualify as a participant, insofar as sexual activity and sexual relationships relate to impairments concerning 'social interaction':

*We see no reason why sexual activity and sexual relationships would not be regarded as included within the activities listed in s 24(1)(c) (in particular sub-para (ii)); nor why the way an impairment may affect a person's ability to engage in sexual activity and sexual relationships would not be within the concept of 'social ... participation' in s 24(1)(d). Members of the Australian community can choose to engage in lawful, consensual, sexual activity and sexual relationships; or, they can choose not to. For some people, such activities and relationships will fulfil important human needs; for others they may be less important. That is the case with many kinds of social participation in which individuals engage - sport, music, hobbies, political or religious activities. Nevertheless, they are all part of the spectrum of interaction between individuals within a community. The supports to be provided to a person who qualifies as a participant are intended to accommodate an individual's particular impairments and to assist that particular individual to be a participating member of the Australian community ...*⁷⁵⁰

- 6.208 The Federal Court was also of the view that participation in sexual activity was not excluded from being funded through the NDIS:

The Agency's case before the Tribunal was that it 'does not fund' participation in sexual activity. That position can only have been taken, as a policy or blanket position, on the view that activities involving sexual intimacy are outside the scheme of the Act. There were times during argument in this proceeding that such an approach resurfaced, despite disclaimers. The Act does not expressly exclude such activities from being funded supports. Nor has any exclusion been made under the NDIS Rules. In our opinion, there is no implied exclusion of such activities either, and indeed in our opinion the better view is that they are intended to be included. Otherwise, the values, objectives, purposes and guiding principles with which this legislative scheme is replete, where they speak of autonomy, 'best interests', 'exercising choice and control', 'participation in the community', 'full inclusion', 'potential for physical, social, emotional and intellectual development', 'respect for their worth and dignity', 'maximise their independence' and 'maximising independent lifestyles' are to be understood as not meaning what they appear to convey, and as being subject to a limit, by way of a hard and impassable line, at the point of physical intimacy with another human being.

In our opinion, it is clear the legislative scheme intends no such limits or exclusion, and no such hard lines to be drawn. Whether, in a given case, the requested support is a 'reasonable and necessary support' will in our opinion generally be a question of fact, on the evidence before the decision-maker. Subject to matters such as rationality and legal unreasonableness, there may be an area of decisional freedom in the conclusion reached by a decision-maker about whether a support is properly characterised as a 'reasonable and necessary support'. The phrase has a qualitative

*aspect. Accordingly, we do not see any question of erroneous statutory construction as looming as large as the Agency's submissions might have suggested. Nor for the reasons we will explain do we consider the Tribunal erred in its approach.*⁷⁵¹

- 6.209 It further explained that 'reasonable and necessary supports' was to be considered broadly in terms of a participant's life and their participation in the community:

*Nevertheless, there is no doubt that the contextual use of the phrase in this Act links it to public funding to be provided to a participant. In that context, the phrase connotes supports which meet a threshold which justifies - by reference to the context, objects and guiding principles of the Act and the facts of the case - the expenditure of public funds for that support, for a particular participant. As we have already explained, the phrase also needs to be understood taking into account what has qualified a person as a participant, and the links between a person's impairment and their full participation in the community, in the same variety of ways as persons without a disability might choose to participate. It is not accidental, in our opinion, that Parliament has chosen the term 'participant' to describe individuals who will receive funded support: the choice of that term reinforces, as we have sought to explain, that the driving objective of this Act is the holistic, improved and increased participation by persons with disability in the life of their communities, and in life itself. And, as we have explained, choosing to engage in lawful, consensual sexual activity (or choosing not to) is an ordinary part of living in such a community, and of living a full and independent life.*⁷⁵²

- 6.210 In the aftermath of the Federal Court decision, Former Minister for the National Disability Insurance Scheme, Stuart Robert, engaged in a series of media interviews where he reduced the woman's claim to funding for 'prostitutes'. For example, in one he stated 'I don't believe Australians think that it's reasonable that they should be coughing up for the services of prostitutes.'⁷⁵³ In response to these comments, the claimant in the litigation expressed concern that the Minister's morals were influencing his Ministerial role in relation to the NDIS and emphasised the importance of the NDIS funding to her life:

Jane, who was motivated to speak out after seeing Robert make increasing reference to her case and "prostitutes" in media interviews, said his comments were "very derogatory to both disabled people and sex workers".

"It's not just about seeing a 'prostitute' as Minister Robert would have us believe," she said.

"It was suggested to me [I should] go to a dating site. It's not that simple. What he's suggesting is that there are ... no significant benefits to people with disabilities from seeing a sex worker and it's just about the act. The service that sex workers provide is much more than just the actual act."

Jane has received \$10,000 a year for the sex worker services following the court's decision.

"I can't afford to pay for it myself," she said. "It's been so beneficial in helping maintain my mood and self-esteem and maintaining my sense of wellbeing."

*Robert has previously said people should use their own money to access such services if they wished. "I just don't think he's in touch with how an average person with disability is supposed to fund the services of a sex worker," Jane said.*⁷⁵⁴

- 6.211 The *WMRF* decisions are an important and positive development in recognition of the importance of funding and supporting sexual pleasure for women with disability. However,

the political response to these and recent moves by the now former government to reform the NDIS indicates the fragility of these decisions in a context of widespread gendered ableism towards women with disability's sexuality. WWDA asks the Royal Commission to explore how to legislatively entrench rights to NDIS funding for women with disability to access supports for sexual activity, sexual pleasure and intimate and/or sexual relationships. As part of this exploration, the Royal Commission is encouraged to explore the NDIS's role in supporting sexuality across its various functions and contexts, notably in the context of disability residential settings and restrictive practices where economic efficiency might be a driving consideration in whether sexuality is supported. Otherwise there is a risk that there will be two separate approaches to sexuality – one for women with disability living in the community focused on empowerment and participation, and another for women with disability (particularly with intellectual disability) living in disability residential settings focused on incapacity and restriction. These concerns about the impacts on sexual and reproductive justice of the NDIS's operation should be understood in a context of the low representation of women with disability in the NDIS *and* the 'administrative burden' of the NDIS which can disadvantage women with disability (such as those who are socially isolated and economically disadvantaged and living in group homes) who do not have the supports to 'articulate their goals and needs to street level bureaucrats ... in a way that aligns with 'the system' or bureaucrats' worldview'.⁷⁵⁵

Sex Education and Information

6.212 Women and girls with disability can have limited access to education and information about sex, including how to foster positive, enjoyable and pleasurable sexual experiences and how to identify and avoid harmful encounters. This lack of education and information is a form of ontological violence in denying to women and girls with disability the status of full sexual subjects and agents.

6.213 WWDA has noted that:

There is a lack of accessible and appropriate information and education resources about the full range of sexual and reproductive rights of women and girls with disability - for women with disability themselves, the service sector, and the broader community. This includes the right to seek, receive and impart information and ideas concerning sexual and reproductive rights in an accessible format. Governments and service providers rarely provide information in the full range of accessible formats, such as in sign language, Braille, large print, audio, Easy English, plain and/or non-technical language, captioned video, in languages other than English, or through the provision of accessible and usable web sites.

For many women and girls with disability, knowledge of sexual and reproductive rights and health has been shown to be poor and access to information and education opportunities are limited.

Sex education for women and girls with disability is wholly inadequate, often focused exclusively on reproductive health and taught from a heterosexual perspective.

Women and girls with disability are largely excluded and ignored in sexual and reproductive rights and health policy, service and program development, including the development of information, education and training resources.⁷⁵⁶

6.214 WWDA also notes the lack of inclusive sex education for girls with disability:

There is research, reports and resources aimed at reducing gender biases in curricula

and educational culture, as well as the roll-out of respectful relationship programs aimed at challenging the gender stereotypes and gender inequality that underpins violence against women and girls.

However, women and girls with disability are not explicitly included nor is intersectional discrimination and inequality necessarily acknowledged in these reports and resources. Women and girls with disability do not have positive portrayals “in curricula, books, media, popular culture and so on”. They are likely to be excluded from sex education and respectful relationship programs and not develop a sense of their own bodily integrity, what constitutes respectful and equal relationships and what constitutes violence, abuse, neglect and exploitation in educational and other environments. They remain stereotyped as burdens and recipients of care, as passive, genderless, asexual or over-sexed and child-like regardless of age. As a result, “[h]armful gender and disability stereotypes combine to fuel discriminatory attitudes, policies and practices...” against women and girls with disability, which makes them extremely vulnerable to violence, abuse, neglect and exploitation.

The few respectful relationships programs aimed at women with disability and delivered by women with disability are invaluable. However, these programs are usually focused on women rather than girls, they are specific to women with intellectual disability, and they focus on recognising and responding to domestic and family violence. They are often project based so not sustainable once funding runs out, and they are only available in limited locations. There are no comprehensive educational programs aimed at addressing both harmful gender and disability stereotypes for all women and girls with disability that cover the life span beginning from early childhood education, through primary and secondary schooling, in tertiary education and other learning environments.⁷⁵⁷

- 6.215 Yet, the lack of information and education goes beyond that specifically on sex, to a lack of information and education on fundamental concepts such as choice, equality and pleasure which are central to positive sexual experiences.
- 6.216 For example, Judy Huett notes that women and girls with disability are not given opportunities to develop the understanding and language to exercise choice in their lives more broadly:

*Some women and girls with disabilities who can't speak have never had someone help them to learn to communicate. They don't even have a way to say yes and no. Can you imagine what that must be like? How can you speak up for yourself and make decisions if you can't even say yes or no to someone about anything?*⁷⁵⁸

- 6.217 Frawley and O'Shea observed that there are profound limitations in the content and process of development of sex education for people with intellectual disability:

recent research confirms that sex education for people with an intellectual disability has failed to progress from the dominant discourse of biology, protectionism and didactic rules-based content and approaches. It remains specialised and segregated, representing a cascade of didactic interventions promoted by ideas of incapacity, naiveté and acquiescence. It has failed to involve people with intellectual disability in the development of education materials, resulting in a segregation of sex education from the self-advocacy dictum 'nothing about us without us'. There is little recognition in sexuality research or sexuality and relationship education that people with intellectual disability are active sexual subjects, and an almost entire dearth of work which acknowledges their capacity 'to contribute to the development of sex education materials that reflect their experiences and desires'.⁷⁵⁹

- 6.218 The limitations in sex education and information for people with intellectual disability was also observed by a researcher reflecting on a project with women with intellectual disability:

Natasha Alexander, was a participant in a general sexuality workshop for women a few years ago. During one exercise, participants had to write down what gets in the way of their pleasure. There were lots of common themes, including guilt, shame, fear, concern that pleasure was trivial, and concerns about being accused of being too self-indulgent. While writing this journal article, Natasha was reminded of this experience. A group of women without disabilities found it difficult to prioritise their own pleasure. Where does this leave people with intellectual disabilities who may be dependent on others to introduce them to pleasure, support them to seek and find what is personally pleasurable, and to support the maintenance of this throughout their lives?⁷⁶⁰

- 6.219 A study exploring how women with intellectual disability understand sex, relationships and sexual abuse found:

Participants' understanding of sexual intercourse varied from very simplistic, with no apparent understanding of the process of sexual intercourse: "When you haven't got any clothes on and the person lies on top of you," (interview 3) to a broad, relatively sophisticated understanding of sexuality: "in a girl, I think that every couple months or something there is an egg release... and the guy's sperm basically goes up them into the girl's eggs and basically makes a baby... the guy ejaculates his semen into the girl's vagina... [sex is] basically from head to toe like with your lips, your breasts, your vagina."⁷⁶¹

- 6.220 The difficulty accessing information and education about sex and relationships can be exacerbated for LGBTIQ+ people with disability. For example, a report by William Leonard and Rosemary Mann on the everyday experiences of lesbian, gay, bisexual, transgender and intersex (LGBTI) people living with disability, found that: 'Stigma and prejudice against LGBTI people with disability are associated with an inability to include their specific situation and needs in sex and relationships education and resources, placing them at increased risk of STIs and reducing their capacity to develop respectful, intimate relationships'.⁷⁶² In a similar vein, O'Shea and Despott note that in their project gathering stories from LGBTIQ+ people with intellectual disability about experiences of sexuality and relationships that a 'key theme from the stories was the poor experiences with sex education to date, including at school. Storytellers felt excluded from sex education which assumed they were heterosexual'.⁷⁶³

- 6.221 The Royal Commission is urged to interrogate the extent that existing education and information on sexuality for women and girls with disability (including school-based education) develops a rich knowledge of sex, sexualities, including an understanding of choice, consent, equality, respect, and pleasure.

Sexual Violence and Other Gender-Based Violence

- 6.222 Women and girls with disability experience high levels of all forms of gender-based violence. As the CEDAW Committee has clarified in its General Comment 35:

Gender-based violence takes multiple forms, including acts or omissions intended or likely to cause or result in death or physical, sexual, psychological or economic harm or suffering to women, threats of such acts, harassment, coercion and arbitrary deprivation of liberty. Gender-based violence against women is affected and often

exacerbated by cultural, economic, ideological, technological, political, religious, social and environmental factors, as evidenced, among others, in the contexts of displacement, migration, increased globalization of economic activities including global supply chains, extractive and offshoring industry, militarisation, foreign occupation, armed conflict, violent extremism and terrorism. Gender-based violence against women is also affected by political, economic and social crises, civil unrest, humanitarian emergencies, natural disasters, destruction or degradation of natural resources. Harmful practices and crimes against women human rights defenders, politicians, activists or journalists are also forms of gender-based violence against women affected by such cultural, ideological and political factors.

Violence experienced by LGBTIQ+ people of all genders also constitutes gender-based violence.

Women's right to a life free from gender-based violence is indivisible from and interdependent with other human rights, including the right to life, health, liberty and security of the person, the right to equality and equal protection within the family, freedom from torture, cruel, inhumane or degrading treatment, freedom of expression, movement, participation, assembly and association.

Gender-based violence against women, may amount to torture or cruel, inhuman or degrading treatment in certain circumstances, including in cases of rape, domestic violence or harmful practices, among others. In some cases, some forms of gender-based violence against women may also constitute international crimes.

Violations of women's sexual and reproductive health and rights, such as forced sterilizations, forced abortion, forced pregnancy, criminalisation of abortion, denial or delay of safe abortion and post-abortion care, forced continuation of pregnancy, abuse and mistreatment of women and girls seeking sexual and reproductive health information, goods and services, are forms of gender-based violence that, depending on the circumstances, may amount to torture or cruel, inhuman or degrading treatment.⁷⁶⁴

6.223 As we noted in Section 2, there is absence of data on gender-based violence. However, current available data does indicate women and girls with disability experience higher incidence of violence.

- [W]omen with disability are twice as likely to report an incident of sexual violence over their lifetime than women without disability (33% or 605,081 women with disability compared to 16% of women without disability)⁷⁶⁵
- Over their lifetime, men with disability are 2.6 times as likely to report sexual violence compared to men without disability⁷⁶⁶
- Since the age of 15, one in three women with disability report emotional abuse by a current or previous partner (37% or 712,076 women with disability compared to 20% of women without disability)⁷⁶⁷
- While people with disability experience higher rates of stalking than people without disability, women with disability are most at risk of being stalked⁷⁶⁸
- Women with psychological and cognitive impairments have very high rates of all types of violence, particularly physical violence, sexual violence, partner violence and emotional abuse⁷⁶⁹
- One in two women (334,076 women) with psychological and/or cognitive impairment have experienced sexual violence in their lifetime.⁷⁷⁰

6.224 Following its review of Australia in 2019, the UN CRPD Committee re-iterated its ongoing concerns regarding the lack of data and information on all forms of violence against women and girls with disability. The Committee specifically highlighted its concerns at “the limited number and scope of instruments to collect data on violence against women and girls with disability”, and recommended that Australia ‘address the methodological restrictions in data collection instruments used to capture data on violence against women and girls with disability.’ The Committee also recommended that Australia:

- Establish a national accessible, oversight, complaint and redress mechanism for persons with disabilities who have experienced violence, abuse, exploitation and neglect in all settings including all those not eligible for NDIS and particularly older women with disabilities;
- Ensure inclusion of women and girls with disabilities in the National Plan to Reduce Violence against Women and their Children beyond project based programs and activities;
- Ensure gender and age-sensitive services to address gender-based violence that are inclusive and accessible for all women and girls with disabilities and ensure staff are adequately trained.

6.225 Gender-based violence is harmful in itself, giving rise to significant physical and psychological injury. However, sexual harassment and sexual assault also has longer term impacts on women and girls with disability, including violating their sense of self, compromising their ability to trust others, damaging their intimate, familial and social connections, and exposing them to criminalisation and incarceration.

6.226 Gender-based violence can also be perpetrated against women with disability through the control associated with guardianship orders, as Queensland Advocacy Incorporated illustrated through Wendy’s experiences:

Wendy is a 55-year-old woman who lives in regional Queensland. Unfortunately, Wendy suddenly lost her life-long partner and became unwell and was admitted as an inpatient to a mental health unit. During this time, Wendy’s two brothers made applications for an interim and substantive order seeking to appoint them both as Wendy’s guardians and administrators under the Guardianship and Administration Act 2000 (Qld). Wendy’s brothers did this without consulting her. In accordance with these applications, the Queensland Civil and Administrative Tribunal made an order appointing her brothers as her guardians for most personal matters and administrators all financial matters.

Wendy and her brothers had an amicable relationship prior to this order, however, after the order was made, Wendy began to feel as though her brothers were controlling all aspects of her life and not consulting with her prior to doing so. Because her brothers were appointed as guardian for the personal matter about who Wendy could contact, her brothers became controlling over who Wendy could contact and made attempts to prevent Wendy contacting her new partner. Wendy was also denied access to her savings account and had noticed money was being spent from her accounts by her brothers without any communication or justification of the expenses. This level of control left Wendy feeling incredibly anxious and upset and as though her relationship with her family had significantly changed. To remove herself from this level of control by her brothers, Wendy made an application to remove them as her guardians and administrators and was ultimately successful.⁷⁷¹

6.227 Women with disability who have insecure migration status can experience gender-based violence related to coercion exercised in relation to the threat of deportation, as illustrated

by the Multicultural Disability Advocacy Association:

Participant D was on a bridging Visa in Australia and had no family members to assist her. She relied heavily on her husband. Her husband would continuously control her, isolate her from the rest of society, not allow her to walk out of the house without his permission. She states that her husband would control the finances and not give her any money and tell her that she could not seek any welfare to assist with her children given she is on a bridging Visa. If she tried to oppose him with anything, he would tell her she would be deported, including if she ever was to seek help or go to the police. Participant D stated that she dealt with the coercive control and abuse until she was given her permanent residence. Participant D stated that when she initially spoke about her situation, it was not considered to be criminal behaviour given he did 'not threaten her life in any way.'⁷⁷²

6.228 Women with disability who have been incarcerated are particularly impacted by gender-based violence, as WWDA notes:

Women with disability represent more than 50% of the female prison population in Australia. More than half of all women incarcerated in Australian prisons have a diagnosed psychosocial disability and a history of sexual victimisation. The rate of incarceration of Indigenous women with disability is higher than equivalent figures for men. Indigenous women with disability are at risk of being detained indefinitely, often without conviction, in prisons and in forensic psychiatric units throughout Australia enduring periods of indefinite detention that in some cases exceed years. Women with psychosocial disability and intellectual or learning disability are disproportionately classified as high security prisoners and are more likely than other prisoners to be in high security facilities.'⁷⁷³

6.229 Criminalised women and girls with disability can experience further violation through the criminal justice system, with the level of surveillance, control and intervention in their lives replicating and exacerbating earlier experiences of violence. Tabitha Lean, a *Gunditjmarra* woman, an activist and story teller who describes herself as 'a criminalised Blak woman, whose mental health has suffered significantly across time and space' describes her experiences of control and violation in the criminal justice system in the context of community corrections:

I am called in for urine testing, which is of course conducted by both a man and woman. They want me to drop my knickers, squat over a toilet, and pee in a small cup, and they want me to do this in their presence. "I can't" I say. "I can't do it with him in the room," my head tilting in his direction. He laughs, "one of those" he mutters under his breath, while his colleague smiles in silent agreement. I wonder what "one of those" that I am today. Am I just a plain old uncooperative crim? Am I a feminist who hates men? Am I one of those 'prisoners' kicking up a fuss just to delay the testing while hoping and praying to all that is holy that the drugs dissipate in my system at the speed of light to avoid detection? Or am I just a woman standing before them wanting her humanity to be honoured? To be fair, I am not sure which of those iterations of me they would detest more.

I tell them: "please check my file, I am supposed to do swab tests." He scoffs "why?" and I respond, "because of the PTSD. I can't do this. It's all in my file. There's a letter from my psych." I am shaking now. The anxious heat is rising from my chest up to my throat and tears are threatening to spill from my eyes. I will them down. I tell myself "do not give them the satisfaction Tabs. Do not buckle, do not fold. You got this". Of course, I haven't got this...literally no one ever "has this" in these spaces. They look at each other and say they'll check my records. I am sent back to the waiting room where I have to sit in breathing proximity to my new 'friend'. He sniggers, "bitch". I nod and sit. And no matter what I do, I just can't quite origami my naked legs small enough

to hide them, so instead I tuck them under the chair, away from his leer.

After ten whole minutes, ten minutes of him side-eyeing me, they call me back: “right, you can do a saliva test”. “Thanks,” I say, as if I should be polite and grateful for them following their own procedures. “Yeah, we gotta check these stories out, you crims lie.” Instantly, the saliva in my mouth dries up and all of a sudden my mouth is the most arid of deserts, the kind that are always thirsty and devoid of life. So, for the next thirty minutes I swallow, I roll my tongue around my mouth, I think of food, of anything that could moisten my mouth enough to produce the full thimble amount of saliva. They grow impatient and with every shuffle of their feet I grow more nervous and drier. But I finally produce. I produce the saliva I know will be clean because this Blak body has never even touched a drop of alcohol, let alone an illicit drug.⁷⁷⁴

- 6.230 There are other ways that women and girls with disability may ultimately be punished and further violated following their experiences of sexual violence, outside of the criminal justice context. Restrictive practices such as chemical or physical restraint can be used by disability service providers and aged care service providers as a response to distress and trauma related to sexual violence because this distress and trauma is interpreted as ‘challenging behaviour’ or ‘behaviours of concern’ (or, in the context of women living with dementia, as ‘behavioural and psychological symptoms of dementia). The Australian Cross Disability Alliance describe examples of women with disability having their responses to experiences of violence mischaracterised as ‘challenging behaviours’:

Natalie is 50 years old and is a resident at a psychiatric hospital. She is Deaf, and has intellectual disability, schizophrenia and epilepsy. She lived with her family until her parents were unable to care for her personal needs, and then moved into a residential care facility. During the first three years, Natalie complained that a night worker was hurting her. She also began to experience delusions during this time. Her complaints were not taken seriously and Natalie eventually stopped talking about the violence. However, she began to have violent outbursts and staff reports reveal that she was restrained, sometimes for several hours, due to these outbursts. When the violence escalated to endanger other residents, Natalie was moved to the psychiatric hospital where she was placed under stricter medical supervision. At the hospital Natalie began to wet her bed at night and to pull out large sections of her hair. She was also heavily medicated. A new case manager experienced in working with survivors of sexual assault began to suspect that Natalie had been sexually assaulted. With the help of an interpreter, Natalie disclosed that for over three years, a night worker at the residential care facility had regularly come into her room and sexually assaulted her. The case manager scheduled a medical exam where it was discovered that Natalie had a sexually transmitted disease.⁷⁷⁵

Martha was an adult and has an intellectual disability and autism. Martha had a strong desire to move out of home and this decision was strongly supported by her family due to their desire for her to live a more “normal” adult life that meant living away from her family and also due to the fact that Martha’s family were exhausted after caring for their daughter and her sometimes difficult behaviours with little or no support.

Martha moved into a group home with 3 other women with intellectual disabilities. This home was run by a major disability provider in Queensland.

Martha was sexually assaulted by a male support worker on 2 separate occasions one weekend.

Martha’s parents were still her guardians and were not informed of any allegation of

assault for a number of days after the first disclosure. In this time medical assistance was not sought for Martha. A police report was not made for a number of days after the disclosure as well.

The perpetrator was charged, and found guilty, but acquitted on appeal. This left the family devastated.

Martha began to have a change in behaviour and personality. She became highly anxious, prone to outbursts and quick to anger which could result in her lashing out physically at staff. This would involve a lot of yelling and screaming and crying. Martha's family strongly felt that the staff viewed her behaviour as that of a naughty child and that when she behaved this way she was punished by having positive things (like outings) taken away from her.

The family and the counsellor viewed this change in behaviour after the assaults as a response to the trauma of sexual assault and believed that different responses ought to be provided to Martha in order for her to feel safe.

When the family requested meetings with the provider they continued to inform the family and the counsellor that they were the ones with the "experience" to "deal" with behaviours like Martha's. When the family tried to address this with the service provider they were met with hostility and left feeling like they were viewed as bad parents for not taking a hard enough line with their daughter. The relationship between the family and the service provider deteriorated quite badly, Martha was incredibly unhappy in her living arrangement and the family wished to find a different service provider for their daughter. The service provider and government funding body made it very clear that the funding for the accommodation was attached to their home, and that it would not be transferred with Martha.

Martha and her parents felt trapped by the service provider and felt that Disability Services were unwilling or unable to help their daughter move to a more suitable provider. It was this service or nothing.

The family reached a point where they felt Martha's mental state had deteriorated to the point where they chose to bring her home. They chose no support, rather than leaving them in the care of a state funded group home.⁷⁷⁶

- 6.231 Another way that women and girls with disability may ultimately be punished and further violated following their experiences of sexual violence consequence is through their children being removed. The failure to make available trauma-informed, culturally and physically safe reproductive and sexual health services to mothers with disability can result in women experiencing further distress that can be interpreted by health and social care professionals as their unfitness to parent thus leading to child protection interventions. Mothers with disability who do not have access to appropriate domestic violence services might not want to report violence to police in order to avoid child removal due to stigma and judgement towards women experiencing domestic violence, which is compounded by the stigma towards disability. This is explained by Collings, Spencer, Dew and Dowse:

All these mothers felt they had been doubly victimised. Not only were they subjected to violence but they were then punished by having their children removed. Having survived abusive relationships, they felt they were held responsible by CPA and courts for making bad relationship decisions. While the system rightly prioritises the safety of children, none of these mothers felt they had received information or support that would have helped them leave the violent relationship.⁷⁷⁷

- 6.232 For example, the Australian Cross Disability Alliance recounted the experience of Andrea, a woman with intellectual disability:

Andrea lived in a violent relationship with her husband. Police had been called to Andrea's home on a number of occasions as a result of the violence, but advised Andrea there was little they could do for her. Andrea became pregnant. She delivered her baby in the local hospital. A week later police arrived at her house with child welfare officials. The police physically restrained Andrea whilst the child welfare officials took the baby. Andrea was told at the time that her baby was being taken because Andrea had an intellectual disability and because there was a history of domestic violence. Andrea was never offered counselling or any form of support for either the removal of her baby or the domestic violence. Andrea's baby was never returned to her...⁷⁷⁸

- 6.233 Maher et al describe some of the punitive dynamics of at the intersections of gender-based violence and child protection systems:

... assessments about the legal capacity of women with disability and a failure to accord women their rights have a significant and deleterious impact in the particular experiences of mothers with disability. These mothers faced existing patterns of the removal of their children, which were exacerbated when women experienced violence of diverse types. It is well-established in family violence research that child protection intervention may work to penalise mothers: the intersection of this child protection presumption or pattern with the exclusion or marginalisation of women with disability creates specific patterns of gendered disability violence where women and service providers were constantly fearful of the removal of children.

- 6.234 Maher et al illustrate these through the observations of three professionals:

So how to fix that, what would you want? You'd want accommodation where a woman with a disability could move in with her children where there was a capacity to bus the kids to the school they were always at, to keep things as organised as they could be it at all possible, help support her, put things in place, get the navigator to apply, and so on. You'd need a system where she can be sat straight again, really, instead of having a very unsophisticated system, panic, cover their own bottoms, and put all this stuff in place. Now, it doesn't mean that every woman with a disability who's been the victim of family violence will end up being a great parent who can do those things, but they need an opportunity to do it, and to prove it. (Justine, criminal justice process organisation)

And as I said my sense of child protection is that we see them at disproportionately higher rates. So, I think that the department's probably more inclined to intervene where they see a mother with a disability because the way—I mean some of the policy failings of that system are that it's geared very much towards mums especially in violent relationships and putting the responsibility on them and so the onus is on those mothers to make sure they're being protective. And that's not a system that's about making the perpetrator visible and the perpetrator accountable for their behaviour, it's often about the victim who is also a parent of children who are victims being responsible for protection. (Madeleine, specialist violence service)

Where there are effects of trauma from domestic violence and the parties have to go through family reports and things like that, often those effects of trauma can be used against that woman as a kind of evidence of a lack of parenting capacity, whereas in fact, getting out of the situation is going to be a path to healing and that situation's going to improve, particularly if the parties are kept apart. I think in all of those situations, having disabilities is an additional barrier or burden or difficulty. (Janice, specialist violence service)⁷⁷⁹

- 6.235 Thus, gender-based violence is a form of interpersonal violence with immediate,

embodied impacts as well as giving rise to slow violence that degrades women and girls' opportunities and wellbeing across their lives.

- 6.236 Conventional policy understandings of violence against women does not capture the full complexity and scope of disabled women's experiences. For example, DPO Australia noted in its 2019 shadow report to the UN Disability Committee:

*The National Plan to Reduce Violence Against Women and their Children 2010-2022, is Australia's main policy framework designed to prevent violence against women. The National Plan focuses only on sexual assault and domestic/family violence in the context of intimate partner violence. It conceals and renders invisible, structural and institutional forms of gender-based violence related to law, the state and culture that women with disability not only experience, but are more at risk of. It excludes reproductive rights violations and many of the settings and spaces in which women with disability experience violence.*⁷⁸⁰

- 6.237 One of the key challenges in recognising and responding to gender-based violence against women and girls with disability is that often women and girls with disability are not listened to or believed.⁷⁸¹ Thus, the interpersonal physical or sexual violence is then compounded by epistemic violence (a point we explore further below in the context of justice system responses). This challenge of being believed is evident in the context of RACFs. Women with disability in RACFs experience sexual violence, including from staff and other residents.⁷⁸² This is illustrated by the experiences of an older woman with disability called Katrina:

*[A] frail old woman in her 90s who suffered from some mobility issues and who lived in a residential aged care facility. One day Katrina went to the kitchen area of the facility to make herself a cup of coffee. While she was there, a carer approached her, shoved her in a corner and touched her in the genital region. He mocked her and dared her to complain, saying that no one would believe her and that he would be back to give her more. Katrina was shocked and devastated by this. She was afraid to go anywhere in the facility and became depressed.*⁷⁸³

- 6.238 Research suggests this is particularly problematic for older women with dementia, because their disability means they are less likely to be believed or understood when they disclose sexual assault and police are unlikely to pursue the matters. Moreover, their distress might be perceived as a behavioural symptom of their dementia and thus responded to through the use of restrictive practices.⁷⁸⁴ The impacts for women living with dementia are particularly dire, as noted by Smith in their systematic review of literature on sexual assault of older people in nursing homes: '[w]ithin a year of being assaulted, 50% of victims died ... Considering older people have an increased risk of mortality after traumatic experiences or of suffering from anxiety disorders, it is reasonable to postulate, the sexual assault can contribute to an accelerated death.'⁷⁸⁵ For example, one woman recounts the story of her mother 'Sandra' being chemically restrained following sexual assault in a RACF:

Not long after mum was admitted to a residential aged care home, she reported that she had been raped. She reported this on multiple occasions over a week and the staff filled out a number of incident reports and called in their nurse practitioner, who then contacted us. We were asked to come into the aged care home for a family meeting. At the meeting, the facility manager said they wouldn't allocate any male carers to mum unless it was an emergency. They said they would keep the door of her room closed to "improve her dignity and reduce male contact given current belief" – which was that that she had been raped. The staff wondered if she has a urinary tract infection and was confused; a dip stick of her urine was all clear.

Male staff continued to provide care and mum became more and more agitated

with them, referring to them as rapists. Her agitation got worse and she was causing disruption to other residents.

The residential manager reported that mum's "hallucinations of rape" at a family meeting. Mum became increasingly agitated and the staff called in her GP. She had bruising on her arms and staff told us that this was 'self-harm'.

The Dementia Behaviour Management Assessment Service (DBMAS) was contacted by staff to manage mum's agitation. They were not told about rape allegations.

A Geriatrician referral was made for a review of mum's medications and the Geriatrician noted the rape allegations and asked if allegations had any "background". The Geriatrician changed mum's medications but did not pursue the rape allegations.

The staff did not contact the Department of Health or the Police as part of their compulsory reporting requirements at this point.

We were not given information about sexual assault services to support mum or us.

The local Elder Abuse Service was not contacted.

The GP was called and wrote in mums care record that she had "ideas of being raped", but no action was recommended. Mum was prescribed haloperidol to treat her agitation. She was given a drug overdose; she had four doses of Risperidone, became psychotic and was admitted to a hospital psychiatric ward.

Mum was transferred to the local hospital for her "behaviour" and treatment of her agitation. Her admission record noted that "polypharmacy is a significant issue" and staff wrote that she had "delusions of being raped" and was "preoccupied with thoughts of sexual assault." She was agitated on admission and was shackled by her ankles to her to a bed in the Emergency Department because she was so distressed. She was given more antipsychotic medication and the staff queried whether she might have a urinary tract infection. Six staff held her down to insert a urinary catheter for a urine sample. She was treated for a urinary tract infection.⁷⁸⁶

- 6.239 Sandra's story highlights, among other things, the importance of trauma-informed aged care provision in the aftermath of sexual violence. In general, previous experiences of sexual violence, including childhood sexual abuse, can impact women and girls with disability's experiences of personal care, especially when trauma-informed frameworks of care are not provided. For example, for rape survivors who require personal care, often daily living may be triggering. Routine care provision when done by males might be particularly triggering, such as having a male carer having to touch their genitals or stand over them to perform personal care; or, when in a hospital setting, having to be touched and rolled to prevent pressure sores and having only male staff available to do this. When service providers or institutions cannot ensure female staff are available to support the personal care of women and girls with disability, full and free consent to care and touch is not possible. Experiences of personal care may instead be viewed through a lens of coercion, with the denial of trauma-informed care and availability of female staff effectively restricting women with disability's right to safety, dignity and respect. Vanamali Hermans' personal submission to the Royal Commission on the experiences of her mother (Julie Hermans, a Wiradjuri woman) in institutional settings (hospitals and group homes) illustrates this issue:

Julie was a survivor of childhood sexual abuse. This trauma greatly impacted her throughout her adult life and prevented Julie from ever feeling safe. When Julie acquired her physical disabilities and become reliant on others for personal care, this deeply troubled her and became a source of constant triggers.

It was evident throughout the support Julie received both in hospital settings and her group home that none of the care she received was trauma informed. This was something Julie, me, Husband Frank and advocate Jamelle constantly had to bring up with staff, however little ever changed.

When Julie was being washed or changed, she would often have male staff leaning over her. She felt helpless. In hospitals, when Julie needed rolling to prevent pressure sores, she experienced similar triggers, with there only ever being male wardsmen. This would lead to panic attacks and what can only be described as a highly distressing situation for Julie.

Despite the labour and emotional energy it would take for Julie to have to constantly disclose to workers she did not feel safe being touched in certain situations because of her history of trauma, she often felt her disclosures were ignored or not taken seriously.

There was never any genuine attempt by any support workers in Julie's life to implement extensive, trauma informed care that could've helped ease the distress Julie encountered. Instead, she was deprived of dignity and the ability to feel safe, having to settle for male support workers or rough handling that never once acknowledged the fear or pain this touch caused Julie.

Julie vocalised that she felt her disabilities also left her vulnerable to further sexual assault within the settings she was confined to. At one point, during her hospitalisation ... she disclosed to me and her advocate ... that she had been sexually assaulted by a male staff member. Again, similar to incidents of physical violence, people doubted the validity of Julie's accusations, and there was never any follow-up or accountability. During other procedures that involved the changing of a urethral catheter, Julie again stated that she felt she had been assaulted with procedures going ahead without her full involvement or consent.⁷⁸⁷

- 6.240 Trauma-informed care is necessary irrespective of when the sexual violence occurred. A recent project on aged care provision for Forgotten Australians / Care Leavers, some of whom will have experienced institutional child sexual abuse, offered a series of recommendations on trauma-informed care which includes:

Ensure every person working in the aged care sector is aware of the existence of Forgotten Australians / Care Leavers and their common childhood experiences.

Implement elements of trauma-informed care, including routine screening for a trauma history and provision of choice and flexibility to meet trauma-related needs.

Rename aged care facilities or units within facilities that have the same names as former orphanages, missions, institutions, or children's homes.

Involve the person in every decision made about every aspect of their care. Consent should be obtained (in some form) for all care tasks.

Always communicate what is going to happen before it happens. Explanations should not be rushed and Forgotten Australians / Care Leavers should be given time to ask questions, refuse any service, or make changes.

Always use the person's preferred name.⁷⁸⁸



Sexual Violence in Disability Segregated Settings

- 6.241 Women and girls with disability experience sexual violence in disability segregated settings such as group homes, mental health facilities and ADEs. Often in these settings, staff, management, and board members are complicit in the violence. The closed nature of these settings means service staff, management, and board members act as gatekeepers to women and girls with disability accessing counselling, legal and other support. Services might take risk management responses to incidents of sexual violence that are focused on protecting the reputation, accreditation and financial interests of the organisation, rather than taking a trauma-informed and victim-survivor centred responses that is focused on the wellbeing and safety of the woman who has experienced sexual violence. Some of these dynamics are explained by Frohmader and Sands:

People with disability who live in institutional and residential settings are highly susceptible to violence (particularly sexual violence) from numerous perpetrators and frequently experience sustained and multiple episodes. Due to the 'closed' nature of institutional and residential settings, away from public scrutiny, this violence is very difficult to detect, investigate and prosecute. This is hardly surprising, given the fact that institutional settings are widely acknowledged to be breeding grounds for the perpetration of violence and abuse, and of cultures that condone violence and abuse. Perpetrators often deliberately target people with disability in institutional and residential settings, particularly those who are least able to resist or make a formal complaint. The common scenario of perpetrators moving between services, either by choice, or as a result of intervention by management, is a serious dimension of the epidemic that is violence against people with disability in institutional environments. Violence is also often built into the very processes of an institutional setting, whereby practices such as forced medication, solitary isolation or seclusion, withholding food and/or money and/or medication, restraint, strip-searches, bullying and harassment - are widely used as 'management' tools and/or as punishment or 'treatment'.⁷⁸⁹

- 6.242 Gender-based violence can occur across the full range of disability-segregated settings, including group homes, mental health facilities, ADEs and day programs. For example, Women with Disabilities Victoria note in relation to ADEs:

a significant number of women with disabilities do not work in open or 'mainstream' employment. Some women with disabilities work in sheltered environments or workshops, such as Australian Disability Enterprises (ADEs) or social enterprises, forms of supported employment. Sheltered workshops are often male-dominated work environments. Because of this, women with disabilities are likely to be exposed to greater risk of sexual harassment, as we know that sexual harassment is more likely to occur in male-dominated workplaces. The sheltered or 'hidden' nature of these workplaces and a lack of independent oversight means it is difficult for women to speak up about violence, harassment or abuse in their workplace, make a complaint, or seek information or assistance. These women are often invisible in the conversation about sexual harassment in the workplace.⁷⁹⁰

- 6.243 WWDA describes one example where a woman in a group home was subjected to ongoing sexual assault:

Linda is a 22 year old woman with a psychosocial and intellectual disability. She resides in a government funded group home with five other women with disabilities. Most of the other women are older – ranging in age between 40-60 years. The organisation managing the group home also runs several other group homes in the area. Linda is told by the support workers that she is being taken to visit "Jack" – a young man with an intellectual disability who resides in one of the other group homes

run by the organisation. Jack is considered to have significant 'behavioural issues' and is 'difficult for staff to manage'. Jack is considered easier to 'manage' if he is not 'sexually frustrated'. Linda is told by the support workers that Jack is her "boyfriend". Linda is taken to the group home where Jack resides and sent into his bedroom. Linda is raped by Jack but Linda thinks that she has to let Jack have sex with her (even though she doesn't want to) because she has been told that Jack is her "boyfriend". This 'arrangement' continues for many months until Linda eventually discloses to a neighbour that Jack "hurts her" when he makes her have sex. Linda shows her neighbour the cuts and bruises on her genitalia and inner thighs. Linda is eventually taken to a sexual assault support service, accompanied by an independent advocate. After one session, the sexual assault support service says they can no longer assist, because Linda won't "open up" to them, and they don't have the resources or the capacity to work with her.⁷⁹¹

- 6.244 The Australian Cross Disability Alliance describes further examples of sexual violence against women and girls with disability in segregated settings:

Shelley is a young Aboriginal woman with intellectual disability who works at an Australian Disability Enterprise (ADE). Shelley has been subject to ongoing and intense workplace bullying and sexual harassment from 3 or 4 other workers. One day, one of the male employees who bullies Shelley, took her by the hand, saying, 'Come on, come with me,' and then grabbed her on her bottom. Shelley reacted, saying, 'Don't do that, don't touch me like that, I don't like it.' She complained to her supervisor, who told the male employee that his behaviour was inappropriate. He is known to have sexually assaulted several other female employees. Although, this behaviour is ingrained in the workplace culture, there has been limited intervention by ADE management, in breach of all the usual protections afforded employees by industrial law. The ADE management claim that sexual harassment and sexual assault is the responsibility of the police to investigate, but the police did not respond or investigate these reports. Shelley began to respond violently to the bullying and sexual harassment, and so ADE management suspended her from her job.⁷⁹²

Josie is 41. She has an intellectual disability and she lives in a group home 'village' style complex. There are a number of other residents with intellectual disability living in other units on the site – some live in units on their own, whilst others share. Josie was raped by a male co-resident within the grounds of the complex. She immediately disclosed the rape to an on-site support worker who advised her to "just keep out of his way". The rape was not reported to the police and Josie was not offered any support or counselling.⁷⁹³

Mia lives in a supported accommodation unit and works for an Australian Disability Enterprise. She has multiple sclerosis. Mia receives support from staff in the mornings and in the evenings. However, there are no staff at her unit during the night. One night, a man entered Mia's unit after the staff had left. He brutally raped Mia. The police were called, but soon decided that they couldn't pursue the case. The police demonstrated no understanding of her disability, and merely passed her off as being unreliable and incapable of providing sufficient evidence. No rape kit was performed. After the rape, service staff took Mia to see a doctor. The service has not undertaken an internal investigation of the incident, as they are of the belief that if the police thought nothing could be done, they had nothing to follow up on. No changes have been made to increase Mia's safety at night time.⁷⁹⁴

- 6.245 Staff might also be perpetrators of sexual assault, as is illustrated by the following examples

A woman with disability in her 50s, Lorraine was "digitally raped" by a staff member while showering in a government-owned group home. An incident report was made

after the woman told another worker what happened, but that report was later rewritten by a supervisor. The worker who allegedly raped the woman was then transferred to another home and the matter was not referred to police.⁷⁹⁵

Several women with intellectual disability living in a group home were brutally assaulted and raped after being left alone with a male employee. For one of the women, it was the second savage attack she had endured, having previously been bashed by a violent male co-resident in another group home. The severely traumatised women were provided with a single session of counselling two weeks later.⁷⁹⁶

Carol, a group home resident, was reported missing. A couple of hours later, she was brought back to the group home by a taxi driver. Blood was found on her underwear and she was taken to the doctor. Carol disclosed to her doctor that she had been sexually assaulted twice by two different people in the time that she was missing. She also said that the group home manager had previously sexually assaulted her. Carol had disclosed the sexual assaults to group home staff a number of months earlier but nothing was done about it. Police advised charges would be laid against the manager, however, proceedings ceased when he died.⁷⁹⁷

Martina has an intellectual disability, and currently resides in a not-for-profit group home with four male co-residents. Martina has expressed a number of concerns with her living situation ... Martina also reported that a male support worker 'pervs' on her while she's getting dressed, and walks into the bathroom while she's in there as there is no lock on the door. Martina feels like she has no privacy in the house. Martina told an individual advocate that she had been sexually assaulted in the group home. She also told the advocate that she was explicitly told by the team leader not to tell the advocate about this incident.⁷⁹⁸

6.246 The role of staff as perpetrators of sexual violence against women and girls with disability, and the failure of disability service providers to take a trauma-informed and victim-survivor centred approach in response to staff violence is illustrated by sexual violence against women with disability in Yooralla disability accommodation. WWDA asks the Royal Commission to consider exercising its powers to compel senior management and board members of Yooralla *at the time of the incident* to appear at the Royal Commission.

6.247 Violence perpetrated on women with disability in disability segregated residential settings by another resident can be characterised as 'challenging behaviour' by workers, and then dealt with through behaviour intervention, rather than considering the support and justice needs of the victim-survivor, as explained by Spivakovsky and others:

[There is an] assumption that the violence that occurs in group home settings is or should be recognised as something that stems from the so-called nature of people with disability and disability services: that violence in group homes stems from disability-related "challenging behaviours."

We do get situations in group homes that become really complicated ... so they are in a sense in a domestic environment and someone can be assaultive towards another person in the group home. And sometimes the person targets a particular person for some reason and that behaviour is often treated as challenging behaviour as distinct from assault or whatever. (Jeff, oversight agency)

The tendency to see violence in group homes as extending from disability-related "challenging behaviours" has a number of real consequences for women with disability. This includes the proposition that if this violence is only understood as

“challenging behaviours”, then it is also only understood as needing to be addressed through the behaviour change approaches used in the disability sector (as opposed to criminal justice approaches). This tension was illustrated by Susan in her account of how she would respond to a woman with disability who is being subject to violence by another person with disability in a group home setting.

Yeah. Okay. So if I had an inquiry about one client perpetrating violence against another client in a disability specific accommodation setting then it would probably fall on whoever is managing that accommodation. So, as you know, the Department has group homes that they own, but they’re managed by different organisations. So if that was to occur ... I would have a conversation with my colleague who manages the group home and they probably would be on top of it. (Susan, specialist violence service)

It wouldn’t necessarily come to me, but if it did, like that scenario, then it would be a case of, and I had one last week as well, a very similar scenario to that one, they removed the victim and said, “What can we do about the perpetrator?” And, of course, sometimes I get calls where the perpetrator is also the victim because it’s a cycle. I might get calls about the perpetrators and it’s a disability worker and, “What do I do?” It’s almost like a secondary consult and it’s like, “Well, have you tried behavioural change?” and a lot of it you don’t want to tell them how to pat a cat, but it’s about two heads are better than one. “I’ve tried that.” “No. I didn’t think to do that,” etcetera, etcetera. (Susan, specialist violence service)

Of course, this is not to suggest that involving the police in these kinds of scenarios would automatically lead to a positive outcome for women with disability either. Indeed, as both Jeff and Erin explained, when the violence that a woman experiences in her group home manages to break through the barriers outlined above, and the police are involved, new complexities arise. ...

we can begin to see how conceptual barriers surrounding what constitutes a “family” or “domestic” setting can leave some women with disability in truly intractable and harmful situations. It also highlights how violence in the disability service sector can be reconceptualised as “challenging behaviour”, which then means the focus remains on the individual with disability as opposed to the accommodation of people with disability in congregate living environments, such as group homes. Many of these stories illustrate the significant work that needs to take place in the disability service sector where group homes are the norm, and where behaviour is controlled by (often harmful) restrictive practices or behaviour modification.⁷⁹⁹

- 6.248 As long as disability institutionalisation and segregation continues, so will sexual violence and other forms of gender-based violence against women and girls with disability. It is thus vital for the Royal Commission to fully explore the role of segregation in violence against people with disability and make recommendations to end segregation across service and justice systems, as outlined by DPO Australia in its campaign ‘#EndSegregation of People with Disability’.⁸⁰⁰ In particular, desegregation and deinstitutionalisation are essential strategies for ending sexual and reproductive violence against women and girls with disability.

Gender-Based Violence Support Services and Resources

- 6.249 Women and girls with disability experience barriers in accessing services for sexual violence and other forms of gender-based violence. These barriers can include physical, technological, informational and communication barriers in design and delivery of facilities,

resources and service delivery. Women with disability also experience discrimination when accessing services, which can mean women with disability do not feel listened to, respected, supported and/or believed, or that they do not receive the necessary counselling and other technical support they need to understand and respond to their experiences of violence.⁸⁰¹ Underpinning this issue of access and availability of services is an ableist understanding of violence against women, as WWDA identified through its empirical project on 1800RESPECT services where ‘ “violence against women” means “domestic and family violence and/or sexual assault” and vice-versa’.⁸⁰²

- 6.250 This narrow view of violence is discriminatory and dangerous to women and girls with disability, as was argued in relation to WWDA’s 1800RESPECT project:

Women and girls with disability in consultations undertaken during WWDA’s six-month “1800Respect Project” consistently and repeatedly identified that the current conceptual framework for the 1800RESPECT service – focusing on ‘two types’ of violence against women (sexual assault and ‘domestic/family violence’), is intrinsically discriminatory, in that it excludes forms of violence that women and girls with disability experience, and are at risk of, as well as the many settings and spaces in which they experience violence. ‘Domestic’ and/or ‘family’ violence is typically understood as intimate partner and/or spousal violence that occurs within the family setting between former or current spouses or partners. ...

Defining, describing and conceptualising ‘violence against women’ as primarily ‘domestic/family violence’ and/or ‘sexual assault’, is not only discriminatory, it is inherently dangerous for women and girls with disability. The focus on narrow conceptual understandings of domestic and family violence as spousal and/or intimate partner violence risks seeing other forms of violence against women, such as those identified with gendered disability violence, become further obscured, resulting in their marginalisation in policies and service responses (including 1800RESPECT) designed to address and prevent violence against women.

Importantly, conceptualising ‘violence against women’ principally as ‘domestic/family violence’ and sexual assault, hides the structural and institutional forms of violence related to law, the state and culture that women and girls with disability not only experience, but are more at risk of – such as forced sterilisation, forced abortion, forced contraception, denial of legal capacity, forced treatment, restrictive practices, restraint, and indefinite detention.⁸⁰³

- 6.251 Language barriers are a significant issue for CALD women with disability accessing support services in relation to gender-based violence, as noted by the Harmony Alliance’s consultations with its members and external stakeholders on the issue of domestic and family violence against CALD women with disabilities:

Language barriers are also a significant concern but providing translated hard copies of information is not always the best solution as many CALD women with disabilities also have reading/learning problems. These translations are often too technical and jargonistic, which further decreases their accessibility for CALD women with disabilities. Translation in itself can sometimes be a tokenistic measure when provided as a default solution without an understanding of the context. Moreover, education and awareness (of entitlements, obligations, and procedures) need to be ongoing rather than a one-off provision of translated information.⁸⁰⁴

- 6.252 Another set of barriers relates to disability services, health services or families acting as gatekeepers to women and girls with disability accessing services for sexual violence and other forms of gender-based violence. WWDA has noted that ‘often when a woman with a disability is seen by a health care worker, the worker fails to perform screening for possible

violence based on prejudicial and stereotypical attitudes about disability.⁸⁰⁵

- 6.253 The main service response to women with disability who experience, or are at risk of violence, is *referral*. Consequently, women with disability seeking support are caught in a cycle of successive referral, without ever receiving appropriate or timely interventions that ensure their pathway to safety.⁸⁰⁶ This is demonstrated by the experiences of Trudy:

Trudy lives with her husband in a rural area. Trudy has a degenerative disability and is reliant on her husband for assistance. Trudy has experienced repeated physical, sexual, and psychological violence from her husband for over a decade. She is socially and geographically isolated, there is no public transport and she is completely reliant on her husband for everything. She has no friends because her husband doesn't allow her to have friends. Her husband refuses any service support even though Trudy's GP suggested district nursing might remove some of the "burden" for Trudy's husband. One day when Trudy's husband goes to the regional shopping centre, Trudy decides to ring a Domestic Violence Crisis Service. Trudy is advised that the service can't assist her directly as they don't have accessible transport and Trudy lives several hundred miles away from the closest metropolitan area. The Crisis Service tells Trudy that there are no women's refuges that take "women in wheelchairs".⁸⁰⁷

- 6.254 Women with disability can encounter difficulties accessing gender-based violence support services because of their intersecting support needs in relation to violence and disability, as illustrated by Louise's experience:

Louise is in her mid-40s and lives in Melbourne. Louise identifies as having cerebral palsy but states her main impairment is osteoarthritis, and she now uses a walking frame. Louise enjoys travelling and is active in the disability rights community. Louise experienced violence from her sister whom she lived with, who was also her care provider. Louise now lives in a private rental.

When attempting to escape her violent situation, Louise contacted several services including housing, disability and family violence agencies. She explained: 'I initially called a housing service but they couldn't help me 'cause at that time I was thinking of moving interstate, but you know, that's when I sort of started getting blocked, you know because it was like domestic violence ones couldn't help me 'cause of this and disability couldn't help me with that, so then I'd go to refuges and caravan parks and I was going through everything you know, hotels, motels anything, trying to find and nothing just seemed to be working. I mean I've got an exercise book just full of all these organisations and that that I approached.'⁸⁰⁸

- 6.255 Women with disability might also have difficulty disclosing violence and accessing support services because of the risk they will lose their necessary support networks, as illustrated by Simone's experiences:

Simone: [The responses to disclosure] didn't take into account all the other things that - all the other concerns that I had for - from the disability's point of view into account. "Would you like to go to a refuge?" Well, Jesus, is it going to be accessible, for one? What happens to my children? Am I going to end up in a care home? It's all of those things that an able-bodied woman wouldn't be running through her head. Am I going to end up in a nursing home? Am I going to end up in assisted care? An able-bodied woman wouldn't be thinking that.⁸⁰⁹

Simone: I mean, even down to when things did become [known] to Child Protection, to Police, at that point even, when Police arrested my husband and removed him from the house, I begged them, you can't put an Intervention Order on him. I can't do this.

I can't live by myself, I can't be by myself. I just actually begged them, you can't do this, I can't look after myself. At that point, they said, "we can't allow him back into the house. He's going to continue to do this and you need to be protected. One day, you will see that this is the right thing to do". It took a while. I did see it was the right thing to do, but he was my carer.⁸¹⁰

- 6.256 There is a dearth of accessible and appropriate information and education resources about violence against women and girls with disability - for women with disability themselves, the service sector, and the broader community. Governments and service providers rarely provide information in the full range of accessible formats, such as in sign language, Braille, large print, audio, Easy English, plain and/or non-technical language, captioned video, in languages other than English, or through the provision of accessible and usable web sites.⁸¹¹ This is reflected in Paula's experience:

In the end, I was told, "We believe something happened but I don't think it's the way that you say it was. But if you want, you can." It's ridiculous. It's like you have made somebody who's autistic and has a brain injury completely confused. Because I can't give exactly the answers that they want ...⁸¹²

- 6.257 These challenges in accessing support services in relation to sexual violence and other gender-based violence are particularly acute for First Nations women with disability, as is demonstrated by a study of domestic violence and disability services in Victoria:

It is widely recognized that Indigenous women with disabilities face additional barriers to disclosure and to seeking help. But little is known about their experiences of violence and of their access to services. UN protocols for the Rights of Indigenous people, people with disabilities, women and children clearly support equitable access to safety and to services, but the reality often is that governments and service providers find Indigenous victims of violence with disabilities as a group 'too hard to handle'.⁸¹³

- 6.258 The study authors found that:

help in Victoria is often unavailable or inappropriate in meeting the needs of Indigenous women and children with disabilities experiencing violence, as those providing the services understand little of the context and/or experiences of Indigenous peoples in these circumstances. The typical 'one size fits all' approach that is so often used in mainstream service delivery has proven to be ineffective in Indigenous contexts, but even more so when we add disability as a further layer of complexity in the Indigenous violence space. Many organisations and services we know continue to operate as silos to the detriment of clients, particularly those who are the most disadvantaged and indeed the most vulnerable.⁸¹⁴

Justice System Responses to Gender-Based Violence

- 6.259 Women and girls with disability experience barriers having their experiences of sexual violence and other gender-based violence acknowledged, investigated, prosecuted and redressed in formal justice system processes. This gives rise to complicity of legal and justice systems in gender-based violence – in failing to create the conditions where further violations are deterred and causing further harm the victim-survivors who seek justice.

- 6.260 Legal definitions of gender-based violence can fail to recognise the forms and contexts of violence experienced by women and girls with disability, as Frohmader and Sands explain:

Current family and domestic violence legislation in Australia provides an example of where legislation aimed predominately to address violence against women,

offers little protection for people with disability (particularly women and girls) in institutional and residential settings. For example, across Australia, there is no uniform definition or consensus as to what constitutes violence against women. It is generally understood in the context of 'domestic', 'spousal', 'intimate partner' or 'family' violence', and this conceptualisation is reflected in most domestic and family violence legislation in Australia. However, domestic and family violence legislation differs across States and Territories - providing different levels of protection and definitions of what constitutes 'domestic violence' and/or 'family violence' and what constitutes a 'domestic relationship'. Some broader definitions include residential settings, such as group homes and institutions, where people with disability often live and interact domestically with co-residents, support workers, service managers, visitors and a range of other staff. However, even where there are broader definitions, domestic and family violence legislation is rarely utilised, largely because violence perpetrated against people with disability in institutional and residential settings is not characterised as domestic/family violence and rarely are domestic violence related interventions deployed to deal with this type of violence. Where narrower definitions apply, which is the case in most domestic and family violence legislation, people with disability in institutional and residential settings are completely excluded from these protections.

An analysis of existing domestic and family violence legislation in Australia indicates that it is neither embedded nor operationalised in a comprehensive human rights frame, it is piecemeal and inconsistent in definitions and scope, does not capture and encompass the various forms of violence as experienced by women with disability in their domestic settings, focuses largely on protection from traditional forms domestic/family violence after the violence has occurred, and offers little in the way of providing legal protection for people with disability, particularly women and girls, including those in institutional and residential settings. In addition, whilst it may be nominally possible for women with disability who experience violence to take measures such as apprehended or personal violence orders, the practical likelihood of such measures being taken by women with disability in institutional settings is minimal. Instead, rather than promoted by legislation, their access to effective protection is dependent on mediation and intervention by others such as staff or carers, who may also be the perpetrators of the violence.⁸¹⁵

- 6.261 Exclusion of violence against women and girls with disability from legal definitions of gender-based violence then means on a practical, legal level that victims-survivors are not able to seek justice through criminal and civil law. On a cultural, legal level, it gives rise to what Fricker refers to 'hermeneutical' epistemic injustice, where there is no shared interpretive frame in which to articulate and recognise these violations as injustice⁸¹⁶ and ultimately to a state of 'ethical loneliness' described by Jill Stauffer where marginalised people are subject to profound harm, and then do not have that harm recognised by government and broader society as injustice.⁸¹⁷
- 6.262 There are a variety of access to justice barriers, such as physical, communication and cognitive barriers, lack of skills of lawyers, discriminatory views held by lawyers and police, and laws related to evidence, limitation periods and legal capacity. The complaints of women with cognitive and psychosocial disabilities about sexual violence are routinely dismissed by police by reason of their perceptions of the women at the intersection of gender and disability. Such perceptions relate to these women being oversexualised (invite sexual violence) or undersexed (incapable of engaging in sexual activity), irrational (cannot be trusted or believed) and incapable (cannot comprehend sex or violence). The challenges can be particularly significant for women and girls with disability with cognitive and psychosocial disabilities, who are seen by reason of their disability as inherently incapable of being believed and as hypersexual or asexual. This is further exacerbated

when women and girls have had contact with police as alleged offenders or under mental health legislation.⁸¹⁸

6.263 For example, WWDA explains that crimes of sexual violence committed against girls and women with disability often go unreported, and when they are, they are inadequately investigated, remain unsolved or result in minimal sentences because of:

- *Lack of reporting of sexual abuse of girls and women with disabilities in institutions, and cover up by staff and management, is acknowledged as a widespread and common problem in Australia, and remains a significant factor in the lack of police investigation, prosecution and conviction of perpetrators;*
- *Police are often reluctant to investigate or prosecute when a case involves a girl or woman with a disability in an institutional settings; and they also fail to act on allegations because there is no 'alternative to the abusive situation';*
- *Girls and women with disabilities, particularly those with intellectual and/or cognitive disabilities and/or psychosocial disabilities have less chance of being believed when reporting sexual assault, violence and abuse than non-disabled women and girls.⁸¹⁹*

6.264 Moreover, women and girls with disability are less likely to be believed when they report violence, as WWDA states:

Despite high levels of violence against women with disabilities in Australia, evidence shows that few cases are prosecuted. It has been well documented for decades that police are reluctant to investigate and report cases of violence against women with disabilities, particularly women with intellectual, cognitive, developmental, psychosocial disabilities. This is in part due to the stereotypical perceptions of women with disabilities that have been found to be operating at almost all levels of the criminal justice system, including police and courts – ie: that women with disabilities are sexually promiscuous, provocative, unlikely to tell the truth, asexual, childlike, or unable to be a reliable witness.⁸²⁰

6.265 The concern of not being believed was also expressed by women with intellectual disability who participated in interviews as part of Illawarra Women's Health Service's project on violence against women with disability:

All the women interviewed expressed concern about not being believed about the violence or abuse they had experienced. It was a typical experience and workers who had clients in this category also noted that their clients often took a long time to disclose because earlier efforts had not been believed or had been dismissed as untrue by family, perpetrators, authority figures and other agencies where they had sought help. ...

Women with intellectual disability are subject to a lot of judgement about their capacity, their health status, and their behaviour and are often not believed when they disclose the amount and extent of violence they experience. The women report that they are often accused of lying or 'telling stories' when they speak about the violence and sexual assault they have experienced.⁸²¹

6.266 Women and girls with disability, particularly those with intellectual disability, might also have a well-founded fear of authority figures which can impact on their willingness to report violence and participate in justice processes. This was observed by Illawarra Women's Health Service in its project:

Women with intellectual disability are significantly disempowered in our society and will often fear authority figures. They will be fearful that they are in trouble if they have to make contact with police, courts, child protection agencies and legal authorities. All of the women that were interviewed and the ones who did not wish to be interviewed expressed this fear and some reported very negative experiences as a result of their contact with authority figures. Some reported a good experience and this depended upon the skills of particular officers. All of the women who had contact with child protection agencies reported very negative experiences and were often told they would be offered case management support which did not eventuate. All those who reported domestic violence had their children removed and several of the women contacted by the project were now involved in long periods of restitution to gain access to their children.⁸²²

- 6.267 One finding from the Harmony Alliance’s consultations with its members and external stakeholders on the issue of domestic and family violence against CALD women with disabilities is the discrimination and harassment CALD women with disability experience in the justice system:

CALD women with disability face severe stigma and harassment as victims and survivors of violence. Stigma against them is rooted in multiple sources of bias and discrimination; including their disability, race, culture, and experiences of violence. The stigma is particularly strong when they report sexual violence. Police as first responders are often a part of harassment resulting from this stigma. This is a significant issue in provision of appropriate responses to CALD women with disabilities experiencing violence.⁸²³

- 6.268 Women with disability have spoken of their negative experiences with the justice system in reporting violence, as reflected by the narrative of Paula:

Paula [on being questioned by the police when seeking support]: Well, or my answers to that would have depended on my credibility, whatever. Also, who did I live with? Was I in a sexual relationship with anybody I lived with? It’s like ridiculous – basically every possible question that they – there’s a whole lot of inappropriate questions. And then they were trying to get me to go through the incidents, which by that time were several years earlier, in detail. And then they were asking the questions like three or four different times and I was getting confused. No independent third person involved.⁸²⁴

Paula: As I said, there’s a lot of people who will not even get as far as the police being made aware because – well, they may not be able to communicate in the first place. If they can, they may communicate it to a gate keeper who may or may not believe them.⁸²⁵

- 6.269 The Australian Cross Disability Alliance, describes similar challenges with the justice system as described through the following experiences of nine women with disability:

Phillipa experienced repeated physical, sexual, and psychological violence at the hands of her partner for over 8 years. Her partner was a ‘well respected’ member of the local community. She tried on a number of occasions to report the violence to the Police, but this was difficult as the Police told her that it was “too expensive and time consuming” for them to organise an Auslan interpreter. The police told Phillipa that she was “imagining” the violence and that she was “lucky” to have a partner who “cared” for her because she was “deaf”.⁸²⁶

A young woman was pressured by her perpetrators to retract a police statement which outlined substantial sexual violence. The police then charged her with making a

false report. One of these perpetrators had previously been imprisoned in relation to sex acts against the young woman.⁸²⁷

Christine, a 39 year-old woman with intellectual disability, was repeatedly raped and bashed in one week by several different men. She lives in a 'semi-supported residential facility', and although she is classified as having "high support needs", she receives only 2 hours of support each day. For the other 22 hours, she is left unsupervised and unsupported. In one of the attacks (in the local park in broad daylight), she was repeatedly anally and vaginally raped and beaten. When she made it back to the residential facility, a staff member made her hand-wash her bloody underwear and garments. The worker wrongly "assumed" that the woman was menstruating (despite her being on an injectable contraceptive) and she was reprimanded for getting blood on her clothes. Christine was too scared to tell the worker what had happened to her because she thought she would "get into trouble". Two days later, the woman disclosed the rapes to her friend who helped her report the rapes to the police. Three of the five police initially involved in interviewing her and taking her statement, asked her friend if the woman might be "making it up". The detectives investigating the case admitted that, although there was now clear evidence that the rapes occurred, there was "little likelihood" of a conviction due to the fact that the woman "has an intellectual disability".⁸²⁸

Paige is a 23 year old woman with multiple impairments, including a neurological impairment and vision impairment. She had been residing in a for-profit supported accommodation facility for approximately six years. She lived with other women, and got on well with her co-residents. Problems arose when a new male co-resident was transitioned into the facility. This man was known for his aggression, and the parents of the other women living in the group home also objected to him being there. One day, there was only one staff member on duty in the group home. This female staff member had previously been physically assaulted by the male resident, and was scared to be left alone with him. When he started to display aggressive behaviours, the staff member locked herself in the office, leaving him alone with the other two female residents. At this point, he raped Paige. The staff member proceeded to call the police and ambulance from the safety of the office. After the police and ambulance arrived, Paige was moved out onto the balcony, away from the male resident. She was left out there for quite a while, before being taken to the hospital by herself. While at the hospital, Paige was asked questions and treated without the support or assistance of her mother or support staff. Indeed, no contact was initially made with her mother to inform her of what had happened. When Paige's mother finally arrived at the hospital, she registered her concern at how Paige had been treated. It was clear to her that Paige was severely distressed and traumatised from her assault and consequent treatment. Paige's mother then took out an apprehended violence order against the male resident on behalf of her daughter. As a result of this, he left the supported accommodation facility. However, when Paige's mother spoke to the police about prosecuting the man, the police tried to dissuade her from this course of action. The police asked her what the point of prosecution was, as he and Paige both had disability.⁸²⁹

Peta has intellectual disability and lives in supported accommodation. She was raped by a support worker. The police were notified, and although believing Peta's evidence, they felt that they wouldn't be able to obtain a conviction against the support worker because Peta's testimony would be deemed unreliable by the court. Consequently, the police didn't pursue the investigation. The support worker is still working for the same organisation, but at a different facility.⁸³⁰

Sarah employed her own support worker to assist her with personal care. Sarah had managed pretty well but now at 45, and with a degenerative disability, it was becoming more difficult for her to manage her personal care. Sarah lived alone. The new female support worker started off well and Sarah felt relieved that she was finally getting assistance. But two weeks later, Sarah was sexually assaulted by the support worker whilst in the shower. Sarah was trapped and unable to fend off the attack. Later she reported the attack to the police, and although it transpired that the support worker had a past history of a similar incident, the police advised Sarah that it would be “pointless” to pursue charges, as it would be impossible to “substantiate” the complaint. Sarah’s “support worker” had passed all reference checks and police checks prior to Sarah employing her.⁸³¹

Nat is an Aboriginal woman in her 40s. She has an acquired brain injury post-surgery. She is in a relationship with a non-indigenous man, who appears very caring. Nat’s disability case manager has not always believed her claims about the partner being violent, and the police have also believed the partner when called to the home by Nat, and did not take action to remove him from the home (leased in Nat’s name) until the guardian advocated strongly for this.⁸³²

Jennifer explained that her ex-partner had ‘sexually assaulted my daughter but he’s in denial’. Her daughter had a disability and her police statement was deemed insufficiently detailed for charges to be laid ... Jennifer’s distress was compounded by the knowledge that her ex-partner escaped prosecution because her disabled daughter was unable to provide police with enough information.⁸³³

Jane commented that she has ‘noticed the young cops are very disrespectful ... and if you have learning difficulties and that, oh wow, they really want to make you dumb’. Similarly she believed the police treated the domestic violence as if it was childish. She pointed out that the police always dropped the perpetrator back at her place. She thought it was like ‘he’s had his time out and now he’s back to you’. So my friend took me to the courthouse and I had to fill out paperwork. ... I had to go to the court the next day ... I got abused by the judge ... [because] I was putting a DVO on a guy. He goes I am sick of women like you coming into here, putting DVOs on guys, and then hooking back up with them. I’ve never done a DVO and ... I could not believe I copped abuse. I felt guilty leaving that court. Jane’s support worker reported attending court with Jane about child protection applications. She recalls that four days a week of child care was a really protective response to the child at that stage – it kept: ... the pressure off and all that sort of stuff. I just remember the judge making a comment – like a really judgemental comment about well if you’re not working, why on earth does she need to be in day care all that time? ... Even knowing all of that stuff. That forever sticks in my mind.⁸³⁴

Sexual and Reproductive Health

6.270 Women and girls with disability can encounter barriers to accessing sexual and reproductive health services, particularly those that provide accessible information, resources and care. This structural neglect is a form of slow violence in and of itself (including, because of the long term health conditions that might go untreated). Moreover, as noted earlier, sterilisation, contraception and menstrual suppression can increase the risk of gynaecological and hormonal conditions, and these side effects might not be considered as significant in relation to women and girls with disability. Waxman connects the absence of reproductive and sexual health services to enduring eugenics logics.⁸³⁵

6.271 Women and girls with disability might experience challenges in accessing healthcare and

support for gynaecological and hormonal conditions. This might be due to the physical, communication and cognitive barriers in accessing services.

6.272 WWDA has noted the inaccessibility of health services:

Discrimination experienced by women and girls with disability is evident in their access to and use of sexual and reproductive health services and programs. For many, the services and programs they require to realise their sexual and reproductive rights are simply not available to them. Where services and programs are available, women and girls with disability are often inadequately served due to a wide range of economic, social, cultural and physical barriers that impede or preclude their access, including for example: inaccessible venues; lack of transport; lack of appropriate equipment; non-inclusive and inflexible service policies and programs; lack of skilled workers; and, pervasive stereotypes and assumptions that women with disability do not have a sexuality.

Breast and cervical cancer screening services are often not readily available or accessible to women with disability, yet a disproportionate number of deaths from breast and cervical cancer occur among women with disability.⁸³⁶

6.273 Inaccessibility is coupled with gendered ableist ideas of women and girls with disability as not worthy of medical attention to alleviate pain and prolong their lives, including discriminatory views of health care workers as noted by WWDA:

Health practitioners and workers have long been seen as complicit in denying women with disabilities their sexual and reproductive rights, and in perpetuating myths and negative stereotypes about women with disabilities. The lack of education and training of health providers has been identified as a major barrier to women with disabilities accessing sexual and reproductive health services. This lack of education and training is borne out in a myriad of ways. For example, many practitioners lack knowledge of disability, hold inaccurate perceptions about women with disabilities, and have a tendency to view women with disabilities solely through the lens of their impairments. Insufficient time to address the full range of needs is a common barrier during encounters with practitioners, as is the general lack of sensitivity, responsiveness, courtesy and support shown to women with disabilities. Health practitioners can have a tendency to treat women with disabilities as objects of treatment rather than rights-holders, and do not always seek their free and informed consent when it comes to interventions.⁸³⁷

6.264 Women with disability have spoken about their negative experiences accessing sexual and reproductive healthcare, as explained by the late disability rights activist Stella Young:

Often I am confronted with presumptions about my sexuality or lack thereof, even from the medical profession. At the age of 23 I saw my endocrinologist about migraines. It was her suspicion that they might have been caused by taking the contraceptive pill. The solution, she said was simple; I was to stop taking it. When I said I was willing to do that, but I'd like to talk to her about other forms of contraception, she was incredulous. She asked me, mouth agape, if I was sexually active. When I confirmed that I was, she laughed. Yes. She actually laughed.

She was unsure about contraceptive options for me, so she wrote me a referral to a gynaecologist. It said: "Stella Young has severe Osteogenesis Imperfecta. Surprisingly, however, she is sexually active and requires contraception." I felt deeply humiliated, as though I had no right to experience sex and to express myself sexually.⁸³⁸

6.275 The negative experiences of women with disability accessing sexual and reproductive healthcare are also illustrated by a woman's experience of visiting a gynaecologist:

The first time I visited a gynaecologist to be prescribed the pill, I really felt like I was a dummy. Visiting the gynaecologist is never a pleasant experience, especially as a young person. When the doctor instructed me to go into an area separated by a curtain to get undressed, her voice became muffled. Being hearing impaired, I couldn't understand her properly anymore, which led to some misunderstandings.

When I got up on the table, I realised she had started talking slowly to me, as if I needed time to process information. She also became quite patronising, explaining to me that sex could be scary, but I shouldn't be afraid.

The whole appointment was quite unsettling, and I didn't return to a gynaecologist for another 8 years.⁸³⁹

- 6.276 Another woman with disability experienced significant difficulty accessing healthcare for menopause:

This is my story of trying to access health care for menopause, as a woman with a brain injury, chronic pain and PTSD [Post Traumatic Stress Disorder]. I started experiencing difficult peri menopausal symptoms when I was 43. I thought I had a pretty good GP, but she outright dismissed my concerns, saying I was too young. Even after I found a study that indicated that women with ABI [Acquired Brain Injury] can get earlier menopause, but she still refused to listen. My symptoms quickly increased to include intense panic and suicidal feelings, but my GP insisted that this was due to the stress from my university studies, and an exacerbation of my PTSD. I dropped out of my studies and many other life and health activities (including this GP) as I struggled to stay alive. I did try to find another GP. But it was 4 years before I found one willing to listen, although by this time, I was a year post menopause and the worst was over. It was a bittersweet moment. I so wish that any of the GPs I saw, had listened, given me support and offered treatment. I believe it would have made the world of difference. Instead, today at 52, I feel as if I only just survived those peri menopausal years, and that I may carry the trauma of those years for some time yet.⁸⁴⁰

- 6.277 Women and girls with disability who are pregnant can be denied access to prenatal care, or experience discrimination in accessing prenatal care.

- 6.278 For some women and girls with disability, there are physical barriers to accessing services. In other instances, information or communication is inaccessible. And, for women and girls with disability who have experienced trauma, including experiences of sexual violence or child removal, prenatal care might not be considered trauma-informed and physically or culturally safe.⁸⁴¹

- 6.279 Stereotypes towards women and girls with disability, or towards other groups such as women who are poor, use drugs, or First Nations peoples, can also shape access to and quality of prenatal care. In particular, there are concerns about health professionals reporting pregnant women and girls with intellectual disability to child protection services and this information being used to remove children, including at birth before they have even had a chance to begin parenting. This risk was particularly pronounced when women had experienced domestic violence:

Two mothers were physically assaulted by their partner during the pregnancy with Sophia saying, '[h]e almost killed me. He nearly put my bone here into my brain' and Jessica explaining, 'I hid my pregnancy because I was in a domestic violence relationship'. When hospital staff became aware of the domestic violence Jessica had experienced, her newborn was removed. Similarly, Beccy, whose newborn was removed due to her partner's violence said that, 'he's no longer in the picture at all so I'm wanting . . . to see if (child) can actually come home.'⁸⁴²

6.280 Denial of access to respectful and dignified sexual and reproductive health services also reflects eugenics logics that ‘disabled women’s reproductive capacity is a biological, moral, and economic danger’, that their sexuality and reproduction is not simply invisible to doctors but actually a ‘eugenic threat’.⁸⁴³ Ultimately, disabled lives are seen as less worthy of preservation and flourishing. This attitude is demonstrated in the following experience of a woman with disability accessing reproductive healthcare:

*Both my husband and I have Achondroplasia a form of Dwarfism, we knew when it came time to start a family there would be questions, we did not expect ignorance and judgement. I was asked by a doctor during emergency department visit early in my pregnancy, “should you be having this baby?” again I played dumb and asked, “what do you mean?”. Again, he said “should you be having this baby, you know with your condition?” meaning my Dwarfism. He was not concerned about my wellbeing he was concerned about bringing a child into this world that could possibly have the same genetic condition as me. I relieved him of his concern by letting him know the baby does not have the same genetic condition.*⁸⁴⁴

6.281 Women and girls also encounter issues related to denial of assistance in relation to pain they experience. The issue of women with disability and pain is complex,⁸⁴⁵ as has been observed in the specific contexts of childbirth⁸⁴⁶ and chronic pelvic pain.⁸⁴⁷ For example, the pain experienced by women with disability can be disbelieved or normalised, and women with disability can be mis-understood as attention-seeking and burdensome in their requests for support to manage or alleviate pain. Cara E Jones argues in the context of endometriosis pain for the need for access to medical treatment *and* accommodations, proposing a

*pain-centric model of disability that centres and politicizes pain. This model politicizes pain, demands medical intervention as well as disability accommodations, and critiques both through a social-constructionist approach that explores how disability intersects with gender, racial, class, national, and sexual identities. There are many reasons to critique medical constructions of endometriosis as a reproductive disorder, but there is no need to forsake medical treatment of endometriosis in the service of social-constructionist analyses. Rather, I have argued, we must approach pain as legitimate and accept that severe pain, regardless of its cause or how it operates, necessitates informed medical treatment as well as disability accommodations.*⁸⁴⁸

Jones argues that reproductive health conditions such as endometriosis need to be acknowledged as disabilities, and the failure to do so reflects gendered assumptions about what counts as disability and in turn who is worthy of accessing support and treatment for pain related to that disability. Indeed, the failure to recognise reproductive health conditions such as endometriosis as disabilities can have broader impacts in terms of access to government funded treatment and support (as discussed in the recent report by the United Kingdom Parliament’s All Party Parliamentary Group on Endometriosis),⁸⁴⁹ as well as workplace accommodations and discrimination protections. Although, any such framings of reproductive health conditions as disability must be attentive to intersectionality and the uneven impacts of ableism, to ensure that all women and girls with disability experiencing these conditions have access to treatment, supports and legal protections, notably women and girls with disability in prisons, group homes and other institutional and segregated settings where their expressions of pain are more likely to be met with a punitive or neglectful response.

6.282 Undiagnosed medical conditions may also give rise to the misinterpretation of pain and distress related to menstruation, menopause, endometriosis and breast or gynaecological cancers as “challenging behaviours” or “behaviours of concern” which are responded to with punitive and violent responses (such as restrictive practices) rather than seeking

to relieve the pain and obtain medical assistance and treatment for the woman for the underlying health issues.

- 6.283 LGBTIQ+ people with disability who need to access sexual and reproductive health services also experience specific challenges. One study noted the fears some LGBTI people have in disclosing their identity to health professionals, with one participant articulating this concern in the context of sexual health services:

I have to go back to my gynaecologist soon, because it's time for my next check-, since the last one five years ago, and since then, I've explored my gender, and come out, and things like that; so I'm sort of wondering if there's any point in disclosing my trans identity, or if I should just closet myself. Because is there any point in doing the work to educate them? Because it's almost certain they won't know already. Or is that energy better spent on just getting through the whole experience?⁸⁵⁰

Parenting

- 6.284 Women and girls with disability experience structural violence in bearing and raising children. As has been observed in the context of sterilisation and abortion, women with disability are not entitled to be recognised as mothers – this is a form of ontological violence that denies their existence as mothers. This ontological violence is not only reflected in people's attitudes – it is also reflected in the available services and products to support pregnancy and parenting. The possibility of disabled mothering is designed out of existence. For example, disability activist Nicole Lee observes from her experiences of pregnancy, noting she felt invisible:

For any woman, pregnancy is filled with a range of emotions. Being disabled amplifies these feelings, throughout my pregnancy I had no idea what to expect. I didn't know any other disabled mothers, or young mothers, and everywhere I went I felt like the odd one out – in the birth classes, the waiting rooms, at the obstetrician's or in the baby goods stores. I felt like I didn't fit; there was just so much stigma. Maternity clothing was limited and didn't fit right on someone like me who was in a wheelchair. Finding a care seat – or a cot, highchair, pram or change table – I could use independently was impossible without modifications and some creative thinking. Going baby shopping was a chore. This was back in the -90s, well before the internet was in everyone's homes, let alone their pockets. So, research meant a lot of driving from store to store.

Shop assistants made a lot of ableist comments; they always wanted to show me what was popular rather than listening to my specific needs in terms of height or the way I needed a piece of equipment to operate. I felt largely invisible. Often, they would talk to Mum instead of me – a common experience for disabled people. ... I'd hoped that finally I might be seen as a woman first and disabled second, but invariably ableism won.

Being pregnant can make any woman feel invisible. ... But for disabled women there are added layers. I regularly dealt with people questioning me: 'How are you going to take care of a newborn?', 'How are you going to cope?' or 'How will you actually change your baby's nappy or bathe them' These comments were laden with judgement and stigma. It was as if they just couldn't imagine that you can be disabled and raise a child. ... My rolling presence raised the spectre of eugenics – the idea that disability should be 'bred out. Still today some people view disability as something to be avoided. ... lives like mine are undesirable and should be avoided at all costs. ...

It felt like everything around me was sending me the message that ‘mothers like me don’t exist’ – yet we do.⁸⁵¹

- 6.285 The structural violence experienced by this can be particularly acute for women with intellectual disability:

The freedom to reproduce and to raise children is generally taken for granted. This is not the case for people with intellectual disability. The commonplace practices of institutionalization and sterilization have denied many people with intellectual disability the opportunity to be parents.⁸⁵²

- 6.286 McConnell and Llewellyn identify ‘the influence of two prejudicial presumptions about parents with intellectual disability’: ‘these parents will inevitably maltreat their children or put them at risk from others’ and ‘any perceived parenting deficiencies (or risks to the child) are irremediable and that there is therefore little point in offering such parents support’.⁸⁵³

- 6.287 In particular, women with disability encounter systemic barriers in accessing family support services. As Llewellyn stated: ‘Women with intellectual disabilities becoming mothers is not usually positively regarded by family, and remains negatively viewed by health professionals and the community more broadly.’⁸⁵⁴ In a similar vein, Collings et al observe that:

Adults with intellectual disability who express a wish to become parents can face considerable opposition from within their social networks and, if they become pregnant, may be pressured to end the pregnancy by family members and social workers. Those who have children live in fear of having them taken away.

Entrenched assumptions by professionals and the community at large about the capacity of persons with intellectual disability to raise a child result in these families facing greater scrutiny and heightened perceptions of risk to children by the practitioners they encounter.⁸⁵⁵

- 6.288 For example, Biripi-Daingatti woman with disability Renay Barker-Mulholland shares her fears related to her parenting her children after being diagnosed with disability:

After that appointment, I sat in my car and cried. My mind was bombarded with questions such as ‘What’s going to happen to my children?’ ‘How am I going to manage?’ ‘What if this gets worse and I can’t look after my kids anymore?’ My whole life I had heard stories of First Nations children being removed from their families – stolen – on much flimsier pretexts. ...

The word ‘disabled’ was avoided in my family growing up – it was considered something to fear. My mum was an incredibly independent person, and her influence ingrained in me the idea that if you just try hard enough you can achieve anything. To her, asking for help was a sign of weakness. ...

My father was a proud Aboriginal and impacted greatly by the trauma our community has endured. To First Nations people, admitting you’re not coping, or that you need help, means you will be separated from your family: you avoid that at all costs. My dad would never say the word ‘disabled’, let alone identify as a disabled person.⁸⁵⁶

- 6.289 Removal of children from mothers with disability is a form of structural violence that has long-term emotional impacts on women and girls with disability whose children are removed, and has broader intergenerational and cultural impacts (notably for First Nations women with disability). Removal of children has intergenerational impacts including impacts from violence against children with disability (particularly sexual violence) in out-of-

home care settings, including residential care, family group homes and home based care including foster care.⁸⁵⁷

6.290 As WWDA has noted:

Women with disability the world over are discouraged or denied the opportunity, to bear and raise children.

They have been, and continue to be perceived as not having a sexuality, dependent, recipients of care rather than mutual care-givers, and incapable of looking after children. Conversely, women with intellectual disability in particular are often regarded as overly sexual, creating a fear of profligacy. These perceptions, although very different, result in women with disability being denied the right to reproductive autonomy and self-determination.

Women with disability considering having and/or raising a child are often subjected to the sceptical beliefs of family members, health workers, and even complete strangers, regarding their ability to care for a child.⁸⁵⁸

6.291 In 2013, the Australian Council of Human Rights Agencies (ACHRA) identified discrimination against ‘potential and actual parents with disability’ as one of three of the most urgent human rights matters in Australia. ACHRA called on the Australian Governments to take national leadership and action on the issue, including better support for parents with disability as “an immediate priority given the discriminatory impact of negative presumptions”.⁸⁵⁹

6.292 First Nations women with disability experience structural racism and ongoing impacts of settler colonialism in their experiences of the child protection system, as Damian Griffis, CEO of First Nations People with Disability recently stated:

The child protection system is hostile and complicated. Child removal is an ever present threat, and reality in our communities. It has become part of the community vernacular, and families live with the legacies of trauma from the removal of their parents and grandparents.

First Nations people with disability are often coerced to surrender their children, rather than having supports so families can stay together.

We see no evidence that the NDIS is positively working with other social services to support families to avoid child protection issues arising, or putting in place supports which prioritise children remaining in their family where child protection concerns occur.⁸⁶⁰

6.293 The experiences of First Nations women in the child protection system take place in a broader context of ongoing impacts of settler colonialism, as the late Gayle Rankin noted:

Colonisation, mistreatment, dispossession from land and the forced removal of children continue to have negative social, cultural, psychological and economic effects on Aboriginal communities and peoples. Aboriginal people and particularly Aboriginal women with disability frequently experience post traumatic stress disorder where they have experienced violence and abuse. Often these conditions go undiagnosed and unrecognised, made worse by inadequate or non-existent mental health support services in regional and remote areas. On that note, I would like to say that a lot of our women don't bring their children forward for NDIS assessment purely because of the Stolen Generation, they took the children away and never saw them again. Underlying many other factors, poverty remains a significant barrier. There

*are few employment opportunities in remote Australia and even fewer for Aboriginal women with disability.*⁸⁶¹

6.294 Women with disability who have their children removed from their care experience ongoing grief. Yet, rarely is the ongoing impact of child removal on women with disability acknowledged, which contributes to the ontological violence that women with disability cannot exist as parents. For example, Heather Smith, a self-advocate with disability, describes the grief she experiences following the removal of her daughter into the care of her mother:

I was going through so much grief when I lost her. My sister was seeing my daughter more than I was, because she lived with Mum. It was absolutely heart-breaking. I got very depressed.

Once when we went on a family holiday, though, I got to hold my daughter. It was the most incredible moment to nurse her and her not be crying.

*I still don't see my daughter much. She's fifteen now. She's such a beautiful girl. I still to this day wish I could have kept her with me, with support in place. She calls me Heather, not Mum.*⁸⁶²

6.295 Following its review of Australia in 2019, the UN CRPD Committee expressed its ongoing concern about 'parents with disabilities having their child more likely removed, often on the basis of disability and by the lack of support in their exercise of parental responsibilities for their children.' The CRPD Committee subsequently recommended that Australia:

- ensure no separation of children from parents on the basis of the disability of either the child or one or both of the parents;
- adopt comprehensive and gender and culturally specific parenting and family support measures for parents with disabilities.

Discrimination and Family Support Services

6.296 Family support services are a core aspect of state-funded support for mothers and having the choice to access these is particularly important in the early stages of parenting, irrespective of disability. This is no less true for parents with disability, with research establishing the significance of access to family support services and related social supports such as housing and income support.⁸⁶³

6.297 Yet, women with disability experience the failure of the state to provide to them any access, or provide safe, accessible and equal access, to postnatal, early childhood and family support services. Women and girls with disability who are parents might also be subject to ableism and greater surveillance and judgement by any family support services which they do receive. This is reflected in the following lived experiences of parents with disability:

*They said because of my intellectual disability I would not be able to take care of a special needs child.*⁸⁶⁴

*I wish they would listen to one person: me.*⁸⁶⁵

*If we got formal supports involved, often they used to come in and they would immediately go to a child protection mode, didn't they, they would immediately want to go, 'Oh, are the children at risk?'*⁸⁶⁶

Instead of just looking at the situation and seeing a parent with a disability and

*deciding they're not coping, they should be providing better support and providing information on alternative ways to parent effectively. Don't be so quick to judge. It doesn't mean that some kids don't need to be removed but it's important to find out why parents with disabilities are coping the way they are.*⁸⁶⁷

- 6.298 For example, the National CRPD Survey Findings 2019 reporting on a survey conducted by the Australian NGO CRPD Shadow Report Coordinating Committee found that: 'More than 15% of people with disability report difficulty accessing services to assist with being a parent.'⁸⁶⁸ Barriers to access can relate to physical, cognitive and communication inaccessibility, including because of ableist assumptions that the needs of mothers with disability do not need to be factored into the design and delivery of services.⁸⁶⁹ Women and girls with disability who have experienced violence and trauma in their lives might not be able to find and access family support services that are trauma-informed and psychologically and culturally safe.
- 6.299 WWDA have also noted that: 'The lack of appropriate, affordable, and available adapted or purpose-built equipment to support women with disability in their parenting, especially of babies and young children, is a recurring theme from mothers with disability in Australia.'⁸⁷⁰
- 6.300 First Nations women with disability might not be able to access culturally safe and non-racist accessible services, and this is particularly significant given the ongoing impacts of Stolen Generations policies and ongoing rates of state removal of First Nations children.⁸⁷¹
- 6.301 The discrimination experienced by women with disability in relation to parenting services is a reflection of and sustains harmful assumptions about women and girls with disability incapable of parenting. These assumptions track on to eugenics logics of women with disability as inevitably unfit to parent. Ultimately this gives rise to ontological violence – that women with disability cannot exist as parents, and the only consequence is to remove their children and thus destroy their identity and being as parents and destroy their connections to their children.
- 6.302 When women with disability *are* able to access family support services, they may often experience discrimination. They can be subject to high levels of surveillance and scrutiny by workers which sometimes gives rise to child protection interventions and which ultimately feels like they were unsupported and set up to fail. For example, Heather Smith, a self-advocate with disability, explains:

As a new mother with intellectual disability, you'd think I would have been offered support, but I only had a maternity nurse who came and visited me once or twice. I was desperate for more help. To this day I really believe I should have been given more support. ... I had a support worker who helped me with meal preparation and shopping but no support with looking after my baby. ...

*... my case manager organised for us to go to a parenting hospital. They taught us how to look after our baby. We spent five days there, but it was hard on us because they were helping other parents and leaving us to the last minute. There I was with a crying baby, not getting any help. I felt like they were discriminating against us because we were two parents with intellectual disability.*⁸⁷²

- 6.303 Jaclyn Lynch who has an intellectual disability and Garry Lynch who has autism spectrum disorder had a similar experience in relation to their son. Jaclyn explains:

During those first few days, when I reached out for support within the hospital I was met with discrimination and judgement. For parents with intellectual disability in Australia, the system is not in your favour. It's almost like people are waiting to catch

you out, to make you look like you're doing something wrong, to prove that you're unable to take care of your child.

I was advised that we should go to a parenting program, where we would need to stay for a week to help with the sleeping and feeding routine. ... We had only been there for two days before Child Protection was called. When the staff realised I was epileptic, they thought I was having a fit while holding Riley. In fact, I was having an anxiety attack because my hormones were shifting. Like a lot of new mothers, I was overwhelmed and needed some support.

Right from the beginning, we did not feel safe at the parenting centre: instead we felt like we were constantly being monitored.⁸⁷³

... It felt like as soon as they had someone with a disability in their centre they rang Child Protection. It felt like blatant discrimination. They were do quick to judge, without waiting to see what we were capable of or offering any support.

... It was sold to me as a place where we would be supported, where we could learn, but they just scrutinised us – tested as and made us feel like we were incompetent.⁸⁷⁴

6.304 The discrimination women with disability experience in relation to parenting services is compounded by the NDIS generally not funding parenting supports for people with disability. Supports are provided to children with disability that might assist those parenting them, but not directly for parents with disability – unless those supports are related to their disability and not their parenting. WWDA is aware of one example where, after becoming pregnant, an Autistic woman with a number of chronic illnesses requested an NDIS plan review to consider additional supports that she may require as a parent. The NDIS refused the review stating that “having a baby is not the responsibility of the NDIS”.

6.305 Sally Robinson et al identify the lack of NDIS funding of family support services:

Families with disability experience compounding difficulty in accessing supports available in the general community. The National Disability Insurance Scheme (NDIS) will not fund support that is provided by mainstream public services (e.g. health, housing, education), yet many families need specialist assistance to navigate mainstream service systems successfully. As a result, families often cannot secure information or access to support. A key criticism of the implementation of the NDIS highlighted in the NDIS Cost Analysis Report was a lack of clarity over the roles and responsibilities of different federal and state government-run services. A reality shared by many families with and without disability is that challenges and unmet needs rarely sit neatly within one sector. Cohesive collaboration is often required across multiple departments and systems in order for the needs of people facing complex problems to be effectively met.⁸⁷⁵

6.306 A research project involving interviews with women with disability who received NDIS funding, observed fundamental issues for women obtaining NDIS-funded support for their parenting role:

several participants had caring responsibilities for children or wanted to be supported to have of a caring role. Several participants felt their caring roles or family relationships were not adequately recognized by the NDIS or by society more generally:

Cat: I don't think there's any sort of acknowledgement often of people who do have disabilities who [also] have caring responsibilities. ...as a person with a disability you must be cared for, you are the recipient.

Melissa: ...my motherhood gets completely thrown out the window. ...they don't see me as a mother, like other women.

Theresa felt that as a mother of several children with disability, she was expected to know how to access care for them. While she had no time to think about support for her own disability, she strongly wished for support to help her access the NDIS and other services on behalf of her children:

Theresa: I don't know whether it would be an advocate or what, that just kind of helps me navigate the process for the kids. So it's almost- I joke that I need a wife, but someone to help me that I can be honest with, and for them not to threaten child protection or tell me I've got bad DNA or whatever.

This quote illustrates many complexities of mothering in the context of disability: difficulty with service access, fear of judgement, fear of having children removed, and a humorous acknowledgement that women bear the brunt of reproductive labour and organising for disability services ("I need a wife").

Child removal and fear of child protection was also a concern for several other participants, who felt that women with disability can attract the wrong kind of attention from government services if they admit to needing help or if their disability is not adequately supported. ...

Jackie and Lily also felt that the NDIS did not provide sufficient recognition of their mothering roles, Jackie connecting this to wider discrimination against parents with intellectual disability:

Jackie: The NDIS came to self-advocacy groups and said what's missing, and I said parents being able to keep their children with the support they need.

Jackie's daughter was not in her care but she wanted support to have a greater role in her daughter's life. However, she found it difficult to access parenting programs because they were not aimed at parents with intellectual disability (using 'jargon' that is difficult to understand) and most were not available to parents who did not have a direct caring role.

Lily reported "absolutely zero consideration" of her full-time caring role for her adult son with "severe and complex disabilities", although both had NDIS plans. While they had support workers during the day, Lily was required to provide her son's care at night, but she had been told not to mention him in her NDIS plan:

Lily: They just say no, we can't include [son] in yours, so they keep it totally separate. With [son]- so they don't give any consideration of- even having any respite. I don't have any respite.

Later, she commented:

Lily: ...it's a real concern that they keep us so separate when we actually live together, and I've never been in any other service, all of our lives, that didn't give the parent consideration, until the NDIS.⁸⁷⁶

6.307 The authors of the project on NDIS and women with disability observe a core paradox at the heart of the failure of NDIS to fund parenting support:

paradox of mothering with disability, where scholars have argued that mothers face both underservicing, in the sense of not being recognized in their caring roles and not receiving appropriate supports to undertake those roles, at the same time as overservicing, in the form of surveillance by social welfare agencies and the threat of child removal if they are judged as inadequate.⁸⁷⁷

Child Protection Interventions

6.308 Mothers with disability are significantly overrepresented in child protection systems in Australia.

A parent with disability in Australia is up to ten times more likely than other parents to have a child removed from their care.

Approximately one in six children in alternative or out of home care has a parent with disability.⁸⁷⁸

6.309 Children may be removed pre-emptively solely on the basis of the parents disability (most often the mother), despite there being no evidence of any neglect, abuse and/or parental incompetence.⁸⁷⁹ Evidence demonstrates that parents with disability are no more likely to maltreat or neglect children than non-disabled parents.⁸⁸⁰

6.310 Over-representation in child protection systems is particularly pronounced for First Nations women with disability.⁸⁸¹ The experiences of First Nations women with disability needs to be considered in the broader context of the role of state child removal in settler colonialism and Indigenous dispossession, displacement and genocide.⁸⁸²

6.311 A 2013 report by the Victorian Office of the Public Advocate (OPA) which examines the removal of children from the care of parents with a disability through the family law system, asserts that in relation to people with disability and their right to parent, current policy in Australia appears to be based on the following broad propositions:

- People with disabilities cannot be competent parents;
- It is rarely in the best interests of a child to be raised by parents with a disability; if a case has been made for removal of a child, then alternative care is seen as better for the child and a less risky solution for the child and for the decision-maker. It also requires no follow-up supervision.⁸⁸³

6.312 These propositions are reflected in Leanne's experience with the child protection system:

My disability has unfortunately made it very difficult to parent in a physical way. Child protection workers measure my parenting ability to the same conditions that they measure other parents who don't have a disability. This is a fact of the system I'm in and it has made it very hard to 'prove myself' to be a fit parent in the Departments eyes. I have fought disability discrimination and unfortunately lost due to the very high burden of proof the Department were asking for. Unfortunately, my children were placed on long term orders because the Department thinks that even though I'm willing, I am not able to parent my children.⁸⁸⁴

6.313 In its report on violence against women with intellectual disability, the Illawarra Women's Health Service noted the 'automatic removal' of children in the context of reporting violence:

The automatic removal of children from women with an intellectual disability who disclose violence is a difficult problem that has been highlighted by this research project. Women often spend years trying to regain custody of their children or even reasonable access arrangements.⁸⁸⁵

6.314 Child protection interventions can cause women with disability extreme distress which can itself be a driver towards removal of their children. For example, after Child Protection was involved with Jaclyn Lynch who has an intellectual disability and Garry Lynch who has autism spectrum disorder, they were required to live with Jaclyn's mother in order to retain

care of their son. This lasted for 6 months until they could move in with Jaclyn's sister and brother. Jaclyn explains of that 6 months:

Throughout this time we were so scared that Child Protection was going to separate us from our son. It was just this constant feeling of being watched, that any day our baby could be taken away. It was so distressing.

Child Protection really wanted Riley out of our lives; the lady who was our contact person seemed to want us to fail. She would try to manipulate me when she did her weekly home visits; often it felt like she was trying to push me to make a mistake.⁸⁸⁶

- 6.315 Child protection interventions (or the threat of these) can have implications in relation to other dimensions of sexual and reproductive violence. Women with disability have been coerced to have hysterectomies after they have given birth to one or more children, who have usually been taken from their care; or as a condition of having access to their child who has been taken from their care.⁸⁸⁷ Women with disability remain in abusive relationships and fail to report the violence due to the likelihood of losing their children,⁸⁸⁸ as illustrated by the following examples:

For Caroline, the grief of child removal compounded the emotional turmoil of post-natal depression: 'I wasn't coping mentally, I was struggling with losing [child and] not looking after myself'. Despite her large support network of family, friends and fellow churchgoers, she stated that 'It's hard for me to trust'. She could talk most easily to her 'a best friend [who had] cerebral palsy and two boys'. However, she did not confide in anyone about the sexual abuse by her ex-partner for fear that 'if I said something to someone, then it will go back to [child protection agency]'. Fear that this disclosure may sever contact with her child altogether was too strong to override.⁸⁸⁹

Jarrah expressed frustration that she felt she could not contact organisations like the ambulance or police because they would report her to child protection services. She explained that she only trusted her support organisation and the children's child care provider.⁸⁹⁰

- 6.316 Women and girls with disability encounter numerous barriers once they are involved in a court matter related to state removal of their children. A recent study conducted about the experience of parents with intellectual disability in child protection court matters discussed parents describing feelings of powerlessness, the bewildering process, not being heard, assumptions of incompetence, double victimisation, dealing with trauma, grief and despair, and inadequate informal support.⁸⁹¹ For First Nations women with disability these experiences intersect with settler colonial practices of child removal, as demonstrated by Jasmine's experiences:

Jasmine is 21 years old. She and her husband both have a mild intellectual disability, and both are Aboriginal. Jasmine and her husband decided they wanted to have a child, and Jasmine soon became pregnant. Jasmine's pregnancy was uneventful, and she gave birth to a healthy baby girl, Tameka. Four days after Tameka was born, child welfare authorities arrived at the hospital and removed her from her parents care. Jasmine, her husband, and their parents (Tameka's grandparents) had been given no indication that Tameka was going to be removed by child welfare authorities. It was almost a month later that Jasmine and her family were told why Tameka had been removed. The reasons given were that Jasmine had a past history of mental health issues (which had been undiagnosed until not long before her pregnancy when she was finally diagnosed with a specific type of mental health impairment and subsequently stabilised with medication). Other reasons given were that Jasmine had displayed 'poor parenting skills' and that she was deliberately 'starving her baby'. In actual fact, Jasmine's relatives advised that she had experienced severe difficulties

with breastfeeding her baby, had repeatedly asked for guidance and help from the nurses, but had either been ignored or told to 'just persist'. A lawyer was engaged by Jasmine's mother and father to have Tameka returned to her parents care. Although the lawyer felt that this was a clear case of disability discrimination and that the allegations could easily be proven as false, the lawyer warned it could take up to a year for the case to be resolved. Jasmine and her husband are now only able to see their daughter twice a week for an hour at a time. These visits are supervised and Jasmine's relatives also believe that the sessions have been secretly video taped with smart phones. Jasmine's great grandmother was part of the Stolen Generation.⁸⁹²

- 6.317 Women and girls with disability can also experience difficulty accessing a lawyer at all, or one with experience working with people with disability. Not all lawyers possess the skills to represent parents with disability, and some might possess stereotyped views about parents with disability.

In Australia, parents facing care proceedings who are assessed as being low income, a test that most parents with intellectual disability would meet, are assigned a publicly funded lawyer (known as Legal Aid). This generalist legal practitioner typically carries a high case-load, limiting their capacity to take the extra time that clients with intellectual disability may need. In any case, these lawyers may lack the specific disability knowledge and skills to take instruction from, or explain processes in ways that parents with intellectual disability can understand.⁸⁹³

- 6.318 Writing in the UK context, Booth et al describe the phenomena of 'temporal discrimination' –where parents with learning disability are not provided the time and support that they need to be accommodated equally throughout the court process.⁸⁹⁴

- 6.319 The particular nature of child protection court proceedings as running over stages can also result in additional barriers:

Care proceedings take place in stages, warranting repeated court appearances before a matter may even be heard and with frequent adjournments on procedural grounds. Between hearing dates, parents are expected to attend meetings where people talk about them or at them and spend far too little time listening to their views. They are interviewed by child protection caseworkers and managers, often without the support of their lawyers or an advocate. Parents have reported feeling intimidated, having words put in their mouths, and feeling like a spectator in the process at these meetings. Research reports that parents are often surprised, and feel further betrayed, when what they thought was an informal conversation with their child protection worker is subsequently presented to the court.⁸⁹⁵

- 6.320 Even if a woman with disability does access a lawyer, there is a problem with lawyers applying to have guardian ad litem appointed. Lawyers might do this if they are of the view they cannot take instructions from their clients, even if this difficulty arises from communication barriers or women's (understandable) anger, grief and distress about the court matter. Collings et al note: 'This practice is commonly granted by magistrates on the recommendation of a lawyer and without any independent and expert assessment of the parent's legal capacity.'⁸⁹⁶ The guardian ad litem then stands in the place of the individual, and is a substituted decision-maker in relation to the proceedings. For example, s 101 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) provides that the Children's Court can 'appoint a guardian ad litem for either or both of the parents of a child or young person, or request the legal representative of a parent or the parents of a child or young person to act as amicus curiae', 'if it is of the opinion that the parent is, or the parents are, incapable of giving proper instructions to his or her, or their, legal representative'.⁸⁹⁷ Section 101 explicitly provides that disability is a basis for appointment: 'Circumstances that warrant the appointment of a guardian ad litem or a request for a

legal representative to act as *amicus curiae* may include that the parent of a child or young person has an intellectual disability or is mentally ill.⁸⁹⁸ The functions of a guardian ad litem are to 'safeguard and represent the interests of the parent' and 'to instruct the legal representative of the parent'.⁸⁹⁹ The legal representative of the parent must 'act on the instructions of the guardian ad litem'.⁹⁰⁰ The appointment of a guardian ad litem in relation to a woman with disability removes her autonomy and choice in the conduct of the court proceedings, and the guardian ad litem might make decisions that are harmful to a woman with disability because the guardian ad litem can instruct the lawyer in ways that are against the explicit wishes of the woman. Appointment of guardian ad litem can be additionally harmful because they can contribute to the conflation of a woman's legal incapacity in the court proceedings and her capacity to parent. While guardian ad litem are supposed to be appointed where a lawyer encounters difficulty taking instructions and legally representing a parent, the reasons lawyers encounter these difficulties could be associated with the lawyer's lack of knowledge, discrimination or lack of time and resources. Moreover, once guardian ad litem are appointed, they can be difficult to remove. A woman with disability under a guardian ad litem needs to prove her capacity which can be difficult if there is medical documentation on the court file which has previously been used as a basis to establish her incapacity or if the woman's presentation and communication in court is (understandably) impacted by her distress, grief, stress and anger at the removal of her child.

- 6.321 The inaccessibility of court processes is a further barrier for women with disability in child protection court matters. For example, the Illawarra Women's Health Service in its report on violence against women with intellectual disability noted in relation to its interviews with women with intellectual disability:

*Some women attend court and child protection meetings without support and advocacy and don't understand the proceedings or the language or terms used. They are asked to read a lot of paperwork and agree to decisions that they often don't understand or have time to think about. This leads to poor decisions being made which can affect them and their families for years. They cannot be expected to navigate this process by themselves.*⁹⁰¹

Legislation in a number of states and territories provides for parents with disability to access support to participate in court processes. Queensland, this support is included in the legislation. Section 106 of the *Child Protection Act 1999* (Qld) provides in part that if a parent 'has a difficulty communicating in English or a disability that prevents him or her from understanding or taking part in the proceeding, the Children's Court must not hear the proceeding without an interpreter to translate things said in the proceeding or a person to facilitate his or her taking part in the proceeding'.⁹⁰² The Western Australian legislation provides that if the Court is satisfied a party 'has difficulty understanding or communicating in English' or 'has a disability' that 'prevents or restricts the party's understanding of, or participation in, protection proceedings, the Court must take reasonable steps to ensure that the services of an interpreter or other appropriate person are made available to the party during the proceedings to facilitate the party's understanding of, or participation in, the proceedings'.⁹⁰³ In the context of Victorian conciliation conferences which are generally attended by the child's parent and the Secretary, the Court can order that an advocate for the parent can also attend, if the parent has a disability.⁹⁰⁴ Other jurisdictions have general provisions for support persons, for example New South Wales legislation states: 'A participant in proceedings before the Children's Court may, with the leave of the Children's Court, be accompanied by a support person'.⁹⁰⁵ Despite these legislative provisions and the existence in some jurisdictions of court support schemes which have shown to assist parents with intellectual disability in court processes,⁹⁰⁶ there is not universal availability of court support for parents with disability across Australia.

6.322 The capacity and ability of a woman with disability to care for her child can be inflected with assumptions about disability, and can even be conflated with a woman's disability (this being particularly the case in relation to parents with intellectual disability). The evidence used to judge potential for parental inadequacy is often based on unfair and invalid assessment procedures that are often carried out in unsupportive environments. This can be compounded (rather than mitigated) by formal assessments of parental capacity in some jurisdictions, which do not necessarily take account of broader circumstances and structural ableism. Collings et al explain:

In an effort to demonstrate willingness to do whatever it takes to get their children back, parents with intellectual disability will often agree to undergo parenting capacity assessments, which are frequently undertaken by clinicians lacking professional expertise in intellectual disability or who are not abreast of the latest evidence pertaining to parents with intellectual disability and their children. Parents with intellectual disability are also often subject to psychometric testing and assessment methods that may be used inaccurately and/or inappropriately to make broad claims about their parenting capacity.⁹⁰⁷

6.323 One parent with disability in Collings et al's study experienced the parenting capacity assessment as an act of discrimination:

they were using the fact that I had an intellectual disability and said I needed a cognitive report done to see how it affects my parenting...⁹⁰⁸

6.324 Jaclyn Lynch who has an intellectual disability and Garry Lynch who has autism spectrum disorder explain their experiences of being in court for their child protection matter, and the importance of supportive advocacy. Jaclyn explains:

I sought advice from a disability advocacy organisation, VALID. They were incredible at outlining what my rights were as a parent with intellectual disability. ... I was also lucky that we had family who recommended a good lawyer, who represented us when the DHHS took us to court. In the trial, Child Protection tried to twist things to make us look bad. It was debilitating and disempowering. Fortunately, though, we won. They didn't have any proof of our incapacity to parent, and we were able to show how capable and committed we were to our son. As the court case concluded, the judge commended me and apologised that I had to go through such a traumatic experience.⁹⁰⁹

6.325 Ultimately, mothers with disability can be held to higher standards of parenting than parents without disability, and this can result in judgements they are neglecting or mistreating their children and putting them at risk of harm, which ultimately results in permanent removal of their children.

6.326 Some jurisdictions do include provisions that attempt to address some of the discrimination experienced by parents with disability. New South Wales has the strongest legislated protections in this respect. For example, s 71 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) provides that while 'the Children's Court may make a care order in relation to a child or young person if it is satisfied that the child or young person is in need of care and protection for any reason',⁹¹⁰ it 'cannot conclude that the basic needs of a child or young person are likely not to be met only because of (a) a parent's or primary care-giver's disability, or (b) poverty'.⁹¹¹ More broadly, the legislation provides that one of the principles in administering the Act is that: 'In all actions and decisions made under this Act (whether by legal or administrative process) that significantly affect a child or young person, account must be taken of the culture, disability, language, religion and sexuality of the child or young person and, if relevant, those with parental responsibility for the child or young person.'⁹¹² Moreover, in the Secretary deciding the appropriate

intervention in response to a report concerning a child or young person, subject to the paramount consideration of ‘the immediate safety, welfare and well-being of the child or young person’ and other children living with that child, ‘any action must be appropriate to the age of the child or young person, any disability the child, young person or his or her family members have, and the circumstances, language, religion and cultural background of the family’.⁹¹³ In a similar vein, South Australian legislation provides that one of the principles of intervention is that ‘account should be taken of the culture, disability, language and religion of children or young people and, if relevant, those in whose care children and young people are placed’.⁹¹⁴ However, these provisions are not across every jurisdiction, and one can question their effectiveness given overrepresentation continues. It is likely that disability might not be explicitly identified as the specific reason for child removal, but that structural ableism shapes perceptions of parenting in a more diffused way or ableism is masked through a focus on other life circumstances.

- 6.327 Legislated support can also be supplemented by advocacy court support schemes. Collings et al conclude on their interviews with parents with intellectual disability who accessed a specialist advocacy programme in New South Wales, Australia that:

It is no small achievement for the advocate to have built such trust with these parents given their mistrust of services and professionals, the traumatic circumstances of their involvement with the service, and the probable permanent removal of their children. The findings in this study suggest that, apart from providing practical support, advocacy offered a relationship model based on reliability, respect and affirmation, which increased parents’ capacity for self-determination. This extends earlier research about the role of an independent advocate for parents with intellectual disability facing care proceedings by showing that, from the parents’ perspective, having a trusting relationship with an advocate who values them as a person also helped build self-confidence. In light of a history of trauma, abuse and bullying experienced by most parents in this study, the finding suggests that parents with intellectual disability can be very receptive to timely, appropriate and sensitive support. As a form of support, advocacy offers the potential to assist parents to build their own capacity for self-advocacy.⁹¹⁵

- 6.328 While there have been efforts to increase access to parenting services when parents with disability are involved in the child protection system and related court matters, it is questionable what services are available to a woman with disability if her court matter is unsuccessful. In such circumstances, women with disability might need support to work towards possible reconciliation or increased contact, or to deal with the ongoing grief and other impacts of child removal. There is lasting grief and trauma where the outcome of care proceedings is for children to be removed from mothers with disability:

Previous Australian research reported on the serial nature of grief for many mothers with intellectual disability who had multiple children removed, and a United Kingdom (UK) study found that the profound trauma caused by the loss of a child led to a deterioration in physical and mental health, sometimes culminating in suicide attempts. Mothers in this study said they felt unable to express their grief for fear of negative repercussions or a lack of trust in counselling.⁹¹⁶

The results [of the authors’ study] echo earlier research from Australia and elsewhere that reported that parents face ongoing trauma following child removal, which can be serial in nature. The parents in this study also shared accounts of grief about the loss of their child and their primary role as a parent. Mothers whose newborns were removed from hospital expressed this as a theft, echoing earlier research with a non-disabled group of mothers involved in child welfare. Coupled with insufficient contact, particularly for those with children in foster care, many of the parents were at risk of suicide and ongoing mental ill-health. This points to an urgent need for the provision

of specialist mental health support and counselling for parents with intellectual disability at the time of their child's removal.

The effects of often lifelong disability-related discrimination and stigma had left many parents with a legacy of low self-esteem and a pervasive sense of fatalism and failure.⁹¹⁷

- 6.329 Mothers with disability involved in care proceedings can be left with enduring feelings of disempowerment and confusion:

Research indicates that parents with intellectual disability exit the legal process feeling that they have been treated unjustly, complicating their ability to come to terms with their loss and compounding a pervasive sense of powerlessness and confusion, which often persists long after their children have been removed.⁹¹⁸

- 6.330 Sometimes the removal of children from women with disability by child protection services is referred to as women 'losing' their children. The politics of this language use is itself an important topic of exploration. To 'lose' something means to cease having it in one's possession or to become unable to find it. This framing of child removal focuses on the physical proximity of the child to the woman and erases the calculated role of the state in removing children from parents with disability under conditions of force and coercion. As such, the framing of removal of children as 'loss' reflects gendered ableist violence because it suggests the inevitability of removal and responsabilises women with disability for removal of their children. This language is particularly important in relation to First Nations women with disability in light of the ongoing and intergenerational impacts of Stolen Generations policies and continued role of settler colonial child protection policies in dispossession and displacement of First Nations people.

Redress for Sexual and Reproductive Violence

- 6.331 In the context of sterilisation, women with disability have spoken about what needs to happen to enable healing to take place for those already affected, and for safeguards to be put in place to prevent others from experiencing this form of torture and from being denied their fundamental human rights:

"There needs to be better explanations for women."

"We need to be given more information about our body."

"We need to have information about the whole process and what it means so that we can make an informed choice."

"We need to build a data base on health issues specifically for women who have been sterilised."

"It time people started to listen! And do what we want."

"It's absolutely necessary to empower women with disabilities to make decisions."

"Let us be in charge of our own bodies."

"Women with disabilities need to have more involvement in the investigation stage so we can say what we want."

"We need to start support groups for women who this has happened to."

“We have to encourage self-advocacy – help women with intellectual disability to say what they want in their lives.”

“We have to provide individuals with proper support to make the right decision for them.”

“Educate professionals especially doctors and support workers so that they understand how it can affect our lives.”

“We must change doctors’ attitudes.”

“It is important that we educate the appropriate people to listen to women with disabilities in the investigation process. We need to see a change in attitude.”

“We have to publicise the issue through public seminars and debates.”

“We must help services listen better to the issues for women with disabilities.”

“We need to educate all the services that have a role to play in making this happen.”

“We need to educate the community, to get them to see it is about the lives of women with disabilities.”

“We need to be changing education at all levels.”

“We have to break the silence about what has happened.”

“We must make sure the voices of women with disabilities are heard at international and UN conventions.”

“We have to change the law so that it stops happening.”

“We need to send a message to politicians that sterilisation is about women with disabilities and how they live their lives.”⁹¹⁹

6.332 Legal authorisation of forced sterilisation, contraception and menstrual suppression prevents these interventions from constituting physical assault under criminal and civil law.⁹²⁰ First, common law doctrine of lawful authority, excludes perpetrators of sterilisation and LARC from criminal responsibility and civil liability where this was done pursuant to statutory or judicial authority (i.e. the various legal frameworks discussed earlier).⁹²¹ Second, guardianship and mental health legislation also generally exclude from civil liability the actions and decisions of those acting in good faith in their functions under the legislation.⁹²² Third, victims support and compensation schemes only apply to violence that would constitute violence under criminal law (even if not established by a court). It is also noted that the common law doctrine of necessity excuses sterilisation in situations of imminent danger even if there has not been formal legal authorisation of the procedure.⁹²³ These implications of legal authorisation of non-consensual sterilisation, contraception and menstrual suppression give rise to one of the key issues with gendered ableist legal violence – there is no accountability and redress available through legal and justice systems.

6.333 While accountability and redress for legal violence through criminal and civil laws of assault is, by definition, impossible through law, this is not a new problem in relation to sexual and reproductive violence. Instead, this is a longstanding problem that has been encountered in overseas jurisdictions in contemporary governments and communities reckoning with and responding to historical legislative schemes enabling sterilisation of people with disability and other marginalised populations (sometimes characterised as eugenics

sterilisation policies). In the context of these historical legislative schemes, the solution has been to establish specialised redress schemes that are administered bureaucratically rather than judicially, thus overcoming the need for people to seek remedies through the courts. Such redress schemes are not restricted by what was illegal at the time of the sterilisation or LARC (although they can also extend to unlawful interventions). Such schemes can also be complemented by forms of structural redress such as apologies and community education that go beyond what is typically available through the individualised legal justice delivered by courts.

- 6.334 North Carolina (United States of America) has taken an approach that couples widespread community education and documentation with support and compensation to survivors. Governor Beverly Perdue established the North Carolina Justice for Sterilization Victims Foundation in 2010 to provide justice and compensate victims who were forcibly sterilised by the State of North Carolina, under the former North Carolina Eugenics Board Program. From 1929 until 1974, an estimated 7,600 North Carolinians, women and men, many of whom had disability, were forcibly sterilised under the Program. A series of Bills in 2007, 2009 and 2011 for compensation were unsuccessful.⁹²⁴ In March 2011, Governor Perdue established a five-member Task Force to recommend possible methods or forms of compensation to those affected.⁹²⁵ The Task Force's Final Report, released in 2012, recommended a package of compensation that would provide a lump-sum financial payment of \$50,000 and mental health services to approximately 1500-2000 survivors.⁹²⁶ The compensation scheme was subsequently legislated in 2013 and commenced making payments in 2014.⁹²⁷ However, it has been criticised by victim-survivors and advocates, including because of its technical limitations: 'The new compensation law says, to be eligible, operations have to have occurred under the state's Eugenics Board. As it turns out, the Board very likely *wasn't* aware of all the sterilizations taking place. Judges and social service workers were greenlighting sterilizations, as well.'⁹²⁸ Additionally, the Task Force's Final Report recommended funding for public education in the form of 'a traveling N.C. Eugenics Exhibit, permanent exhibit memorializing all Eugenics Board program victims and an ongoing oral history project that will tell the full story of eugenics in North Carolina'.⁹²⁹ The public education component 'is aimed at educating future generations about the horrors associated with North Carolina's eugenics past in an effort to prevent future horrors and abuses'.⁹³⁰ The report also recommended 'continuation and expansion of the N.C. Justice for Sterilization Victims Foundation to serve as an organization to support victims and their families and administer the compensation package'.⁹³¹ The Foundation would have an outreach function in order to raise awareness of the program and availability of compensation.⁹³²
- 6.335 Virginia (United States of America), which is the state in which Carrie Buck of *Buck v Bell* was sterilised, became the second state to provide compensation to victim-survivors of sterilisation. A 2015 Bill for compensation did not progress, but \$400,000 was subsequently allocated for a compensation program administered by the victims of Eugenics Sterilization Compensation Program to compensate survivors of sterilisation under the Eugenic Sterilization Act which operated 1924-1979.⁹³³ It has been reported that there are only around 11 known survivors of the eugenics sterilisation.⁹³⁴ The compensation program follows a 2002 apology by the Governor for those sterilised under the eugenics legislation.⁹³⁵
- 6.336 On 1 January 2022, the Californian government introduced the California's Forced or Involuntary Sterilization Compensation Program for victim-survivors of sterilisation, which is being administered by the California Victim Compensation Board (CalVCB).⁹³⁶ The Program has a total of \$4.5 million which is 'to be split evenly among all eligible individuals who apply', with an estimated 600 survivors of sterilisation eligible to apply. There is an additional \$1 million for 'markers or plaques at designated sites that acknowledge the wrongful sterilization of thousands of vulnerable people'.⁹³⁷ This Program follows a 2003

apology for California's eugenic sterilisation program by the Californian Governor⁹³⁸ and two earlier, failed attempts to introduce legislation for a compensation scheme.⁹³⁹ This new program makes California the third US state to provide compensation for sterilisation.

- 6.337 Some US states such as Oregon⁹⁴⁰ and South Carolina⁹⁴¹ have given apologies for people with disability sterilised under eugenics laws, but have not introduced redress schemes.
- 6.338 Alberta (Canada) has compensated large numbers of victim-survivors through settlement schemes following class actions. In October 1989, Leilani Muir filed a lawsuit against the Alberta government for wrongfully classifying her as "feeble-minded," which led to her forced sterilisation. In January 1996, the Provincial Court of Queen's Bench ruled in Muir's favour, and awarded her \$740,000 in damages, and another \$230,000 in legal costs. Leilani Muir's lawsuit was the first one to ever successfully sue the government for forced sterilisation.⁹⁴² Following Muir's victory, hundreds of other victim-survivors of sterilisation also filed. In light of Muir's case, the provincial government responded with the introduction of a Bill 'Institutional Confinement and Sexual Sterilization Compensation Act' (Bill 26) which sought to limit the amount of compensation an individual could be awarded by a court to \$150,000, by invoking the 'notwithstanding clause' in section 33 of the Canadian Charter of Rights and Freedoms. Within 24 hours of being introduced the Bill was withdrawn because of public outrage and an apology was issued. Approximately '500 claimants then settled for \$48-million in 1998. The following year, Alberta agreed to an \$82-million compensation package for another 247 victims of forced sterilization'.⁹⁴³
- 6.339 In 2019, Japan passed a law 'Act on the Provision of Lump-sum Compensation to Persons Who Received Eugenic Surgery, etc' which provides for apologies and compensation of 3.2 million yen (\$37,500) to each victim of the 1948 Eugenics Protection Law. The law allowed doctors to sterilise people with disability without their consent, and operated from 1949 to 1996. An estimated 25,000 people were sterilised without their consent under the law, many of whom were in their teens or younger when operated upon. Approximately 70% of persons sterilised were women.⁹⁴⁴ At the time of the law passing in Parliament, Prime Minister Abe issued a statement apologising and saying every effort would be made to ensure that society did away with discrimination against people with disability.⁹⁴⁵ However, in April 2021 only 1,049 or 3.9% of the total victims had applied for compensation.⁹⁴⁶ In June 2020, the House of Representatives and the House of Councillors' Health, Welfare and Labour Committee Research Office launched a new investigation which involves a survey that 'is based on the principle that Article 21 of the Lump-sum Payment Law states that "the State shall ensure that the situation in which people are forced to undergo surgery to make them unable to reproduce or to undergo irradiation on the grounds that they have a specific disease or disability shall never be repeated."⁹⁴⁷ Disabled People's Organisations and other civil society organisations have made various suggestions for reform of the law in relation to the amount of compensation payable and to enhance the scheme's scope and accessibility.⁹⁴⁸ Additional to the legislative compensation scheme, some victim-survivors have taken court action to seek compensation, with higher amounts awarded. For example, in February 2022 compensation was awarded by a Japanese court to victim-survivors of sterilisation with the Osaka High Court ordering the Japanese government pay a total of 27.5 million yen in damages to three victim-survivors (a male-female couple, and another woman in their 70s and 80s), although they had sought 55 million yen.⁹⁴⁹ Then, in March 2022 a Tokyo High Court awarded 15 million yen in damages to a 78-year-old male plaintiff (although he had sought 30 million yen).⁹⁵⁰
- 6.340 There are also some examples of compensation in Europe. For example, in July 2021 the Senate of the Czech Republic voted to pass a law to compensate people sterilised between 1966 and 2012. The majority sterilised are said to be Roma women, but disabled women are also identified as victims.⁹⁵¹ Survivors are eligible for compensation of 300,000

CZK.⁹⁵² The compensation law follows a government apology in 2009,⁹⁵³ and the government rejecting an earlier Bill in 2015 which provided for up to CZK 300 000.⁹⁵⁴

6.341 These overseas examples demonstrate that it is possible to construct and deliver redress in response to sexual and reproductive violence against women and girls with disability including violations that are historical and/or legal. However, they also highlight some of the context in which redress has failed or has not met the expectations of justice demanded by victim-survivors and the disability community. Thus, these examples serve as a nuanced resource to learn from in developing redress in the Australian context.

6.342 While Australia is yet to introduce a redress scheme specifically in relation to sexual and reproductive violence against women and girls with disability, Australian federal and state/territory governments have introduced redress schemes in relation to other institutional and state harms:

- **Institutional child sexual abuse:** Following recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse,⁹⁵⁵ the federal government introduced a National Redress Scheme which commenced in July 2018.⁹⁵⁶ The National Redress Scheme consists of financial payment, counselling and direct personal response from the institution. The Royal Commission also recommended a national memorial to institutional child sexual abuse survivors,⁹⁵⁷ and the memorial is at the design stage with construction expected to commence in 2022.⁹⁵⁸
- **Stolen Generations:** In the 25 years since the Human Rights and Equal Opportunity Commission Bringing Them Home recommended reparations for members of the Stolen Generations and family members, communities and descendants also impacted by forced child removal,⁹⁵⁹ state and territory governments have introduced reparations schemes for members of the Stolen Generations.⁹⁶⁰
- **Forced adoption:** In response to recommendations for a redress scheme in a 2021 Victorian Parliamentary Inquiry into responses to historical forced adoption in Victoria,⁹⁶¹ the Victorian government announced in March 2022 it would design a redress scheme for people affected by historical forced adoption practices during mid-1950s to the 1980s.⁹⁶²

These provide a basis on which to extend to women and girls with disability equal access to justice through development of a scheme for their experiences of institutional and state harms.

6.343 Therefore, individual and structural redress is an important aspect of responding to sexual and reproductive violence against women and girls with disability, that has already been developed and utilised in numerous overseas jurisdictions and is not prevented by the legality of the violence. WWDA urges the Royal Commission to fully explore options for redressing sexual and reproductive violence, including by learning from Australian and overseas redress laws and practices. For example, People with Disability Australia have recently noted a series of problems with the operation of the National Redress Scheme in relation to people with disability who have survived institutional child sexual abuse:

- *Lack of awareness and inadequate outreach services to survivors with disability, including through the provision of information and advice to Redress support services.*
- *Ableism pervading the Scheme and mainstream support services, which*

operate in a manner that too frequently treats disability as an ‘add-on’ rather than as integral to the Scheme’s workings.

- *Inadequate access to timely and effective counselling and psychological services and lack of alternative social supports survivors may need throughout their lives as possible Redress outcomes.*
- *Arrangements impacting survivors’ legal capacity and decision-making about engagement with the Scheme.*⁹⁶³

6.344 Additional to the role of governments in redress, it is also important to consider the specific roles of disability and aged care services, and legal, health and social care professionals in processes and relations of accountability and repair. Their involvement in accountability and repair is in recognition of the particular complicity of these sectors of society in sexual and reproductive violence against women and girls with disability. For example, Wiradjuri woman Vanamali Hermans observes the complicity of health professionals in violence against First Nations people with disability:

*Since invasion, health professionals in these lands have often acted as agents of control, rather than as agents of care. Settler-colonial states such as Australia have long understood the penal potential of hospitals. ... Nurses, doctors and researchers working today are not individually responsible for these long histories of medical incarceration, but they are still representatives of a profession responsible for the institutionalisation of the poor and marginalised, and the intergenerational trauma of medical abuse. They operate at the direct interface of health and wellbeing, and as such every aspect of the institution must be held to the highest standards of empathy and responsibility.*⁹⁶⁴

6.345 The involvement of disability and aged care services, and legal, health and social care professionals in accountability and repair is important not only to ensure a full response to specific violations, but also because these injustices continue to shape the present and future for people with disability. Historical injustice has a lasting impact because it continues to shape structural conditions in the present.⁹⁶⁵ If not recognised as such, historical injustice can ‘seamlessly permeate contemporary society’ and be ‘an enduring legacy that informs present social practice’ and design of new systems.⁹⁶⁶ There are examples of what some aspects of this accountability and repair could involve from the context of Stolen Generations, such as apologies of professional associations and action plans to address settler colonialism and racism within their professional communities.⁹⁶⁷ In a similar vein, many disability and aged care service providers operated in earlier decades (often under different names), and yet have never reckoned with and been accountable for and committed to repairing the violence and other injustices they perpetrated. Until they are fully redressed, these historical injustices that remain unreckoned with, unaccounted for and unrepaired by disability and aged care services will constitute ‘hauntings’⁹⁶⁸ that will continue to limit the possibilities for the disability community to have trust and hope in disability and aged care services.⁹⁶⁹



7 CONCLUSION: A FRAMEWORK FOR SEXUAL AND REPRODUCTIVE JUSTICE IN AUSTRALIA

7. CONCLUSION: A FRAMEWORK FOR SEXUAL AND REPRODUCTIVE JUSTICE IN AUSTRALIA

- 7.1 In this section, we elaborate on key aspects of WWDA's recommendations outlined in Section 1, in light of the human rights framework for sexual and reproductive rights described in Section 4, the principled and conceptual approach to understanding sexual and reproductive violence as gendered ableist violence discussed in Section 5, and exploration in Section 6 of women with disability's lived experiences of sexual and reproductive violence and the laws, politics and cultural expressions of ableism that enable such violence specifically in our Australian context.
- 7.2 Addressing sexual and reproductive violence against women and girls with disability in Australia must be approached from the perspective of realising sexual and reproductive justice for all women and girls with disability, realising self-determination of First Nations people with disability, ending disability segregation across legal, justice, service, residential, educational and other systems, and addressing connections between ableism and interlocking systems of structural oppression including racism, heteropatriarchy, settler colonialism and neoliberalism. In particular, sexual and reproductive violence has been understood as one aspect of society-wide and deeply entrenched segregation and control that is pervasive throughout the lives and life-courses of women and girls with disability. As such, sexual and reproductive justice can only be achieved when all segregated systems and all practices of control and intervention are ended. Thus, sexual and reproductive justice requires abolition and deinstitutionalisation in relation to existing sites of confinement and coercion, and broader desegregation of disability-specific aspects of legal, justice and services systems, as well as support for community inclusion, independent living and legal, social and economic equality. As long as women and girls with disability are subject to incarceration, coercion and segregation, sexual and reproductive violence will continue. Sections 5 and 6 have highlighted the importance of considering the political economy of sexual and reproductive violence, notably in relation to violence perpetrated against women in the context of segregated and institutional settings. Sexual and reproductive justice involves eliminating the financial incentives for perpetrating violence against women and girls with disability, and to ensure the financial gain to service providers through violence against women and girls with disability is part of what is reckoned with and redressed in holding service providers to account.
- 7.3 Women and girls with disability and their representative organisations (including organisations of First Nations people with disability) must be central to realising sexual and reproductive justice in Australia. Their leadership and contributions must be fully supported (financially, logistically and politically) by Australian and state and territory governments. This is particularly because profound and pervasive epistemic violence that denies women and girls with disability autonomy over their bodies and lives is at the core of their experiences of sexual and reproductive violence. This epistemic violence occurs at the level of individual health, social care and legal service provision and at the structural level through the role of legal and justice systems in denying legal capacity. This epistemic violence sustains assumptions that women and girls with disability cannot make their own sexual and reproductive decisions, and also invalidates their perspectives on sexual desire and pleasure, and undermines their expressions of love, grief, joy, sadness and physical pain. Women and girls with disability can have their experiences of distress, fear, trauma, anger and grief misinterpreted as 'challenging behaviour' or 'behaviours of concern' which then provides openings for punitive and violent responses such as criminalisation, use of restrictive practices, and removal of children. To this end, the Australian Government must fund and support opportunities – including across legal, education, health and disability systems – for positive sexual expression and sexual pleasure, intimate relationships, menstruation, childbirth and parenting. The Australian Government must also recognise,

support and strengthen the role of women with disability organisations, groups and networks in efforts to fulfil, respect, protect and promote their human and legal rights related to sexuality and reproduction, and to support and empower women with disability, both individually and collectively, to claim their rights. This includes the need to create an environment conducive to the effective functioning of such organisations, groups and networks, including adequate and sustained resourcing. Inherent in this, is the need for financial and political support to enable the establishment and recurrent funding of a peak NGO for women with disability in each State and Territory.

- 7.4 Also central to realising sexual and reproductive justice for women and girls with disability is Australian Government compliance with international human rights law. The Australian Government should take a broad approach to understanding which human rights are relevant to realising sexual and reproductive justice. Such an approach must take into account human rights related to equality and non-discrimination, justice and redress, and freedom from violence, including in relation to prohibiting and redressing lawful violence and torture. A broad approach should also extend to rights related to access to resources, supports, inclusion and participation in order to address structural dynamics of disability segregation, financial inequality, and state surveillance and intervention that shape and limit sexual and reproductive experiences. The Australian Government should fully implement recommendations from Australia's reviews under human rights treaties to which it is a party, noting that some of these recommendations are specifically on sexual and reproductive violence (e.g., sterilisation). The Australian Government should immediately withdraw its Interpretive Declarations on the CRPD including Article 12 [Equal recognition before the law], Article 17 [Protecting the integrity of the person] and Article 18 [Liberty of movement and nationality]. The Interpretive Declarations on Articles 12 and 17 are particularly significant to forced and coercive sterilisation, abortion, contraception and menstrual suppression, and to non-consensual and coercive institutionalisation and restrictive practices which can increase risks of sexual and reproductive violence.
- 7.5 Also on the topic of human rights, the Australian Government must ensure its compliance with OPCAT, because much sexual and reproductive violence against women and girls with disability takes place in institutional and closed settings. OPCAT compliance extends to including in the scope of the NPM and related monitoring work the forms of torture and cruel, inhuman and degrading treatment of people with disability experience and the places in which people with disability are deprived of their liberty. Australian and State and Territory independent oversight bodies under OPCAT must categorise group homes, RACFs, closed mental health units, forensic disability units, hospitals, and broader residential facilities for people with disability as 'places of detention' under the OPCAT, and be monitored accordingly. Moreover, these places of detention must be monitored for sexual and reproductive violence, including forms of legal violence that might be misinterpreted as mundane and efficient service provision (e.g., menstrual suppression). On a related note, the Commonwealth Ombudsman as co-coordinating NPM must actively engage with women and girls with disability and DPOs to ensure their 'inclusion and effective participation' regarding the monitoring of all places where people with disability are detained/deprived of their liberty. However, ultimately sexual and reproductive justice cannot be realised until these closed, segregated and institutional settings are abolished, and women and girls with disability can live in the community. Monitoring places of detention for torture and cruel, inhuman and degrading treatment must take place in a broader context of eliminating these places of detention through abolition, desegregation and deinstitutionalisation, in order to end the systems of incarceration and control that are inextricably connected with women and girls with disability's experiences of sexual and reproductive violence.
- 7.6 Human rights must also be integrated into Australian domestic law. One such measure

is to establish and enact a comprehensive, national, judicially enforceable human rights legislation that fully incorporates Australia's international human rights obligations into domestic law. Human rights must also be at the core of disability policy. And the Australian Government, must ensure that national policy frameworks, (such as the Australian Disability Strategy 2021-2031, and the forthcoming National Plan to Reduce Violence Against Women), include as a priority, the development of specific, gendered, targeted measures to address the sexual and reproductive rights violations experienced by people with disability, particularly women and girls with disability.

- 7.7 Realisation of sexual and reproductive justice for women and girls with disability must take account of the particular circumstances of sexual and reproductive violence against First Nations women and girls with disability which are situated in the ongoing structure of settler colonialism. The Australian Government must commit to ensuring that First Nations women with disability are afforded self-determination and have meaningful involvement in decision making, development and evaluation of supports and systems that affect them. Disability service provision is one aspect of self-determination. Rather than First Nations communities having access to disability support that is operated by the state or non-Indigenous NGOs, there should be increased government and non-government support to Aboriginal owned and operated disability services, including in urban, regional and remote communities. Truth-telling and reparations is another aspect of self-determination in the context of sexual and reproductive violence against First Nations people with disability. The Australian Government should develop with Aboriginal communities a comprehensive truth and reconciliation system and related reparations scheme. Consideration can be given to what has worked in the context of various Australian initiatives relating to Stolen Wages and Stolen Generations, as well as overseas developments in relation to other First Nations communities.
- 7.8 Section 6 of this Submission discussed complicity of legal and justice systems in sexual and reproductive violence against women and girls with disability, in enabling and regulating lawful violence against people with disability and facilitating a lack of accountability and redress in the aftermath of such lawful violence, and in failing to provide trauma-informed, accessible and inclusive processes for responding to unlawful violence. Legal and justice systems are central to the very possibility and legitimacy of many forms of sexual and reproductive violence against women and girls with disability, notably forced and coercive sterilisation, abortion, contraception and menstrual suppression, as well as child removal and denial of autonomy over intimate relationships and marriage. Therefore, realising sexual and reproductive justice depends on inclusive and non-violent legal and justice systems. And, inclusive and non-violent legal and justice systems cannot be realised until the Australian Government, the judiciary and legal profession confront and reckon with ableism (including gendered ableism) embedded within legal doctrine. Inclusive and non-violent legal and justice systems are dependent on the enactment of national, uniform and legally enforceable legislation prohibiting sterilisation of children, and the sterilisation of adults with disability in the absence of their prior fully informed and free consent. A related aspect is prohibition of all forms of forced treatment and restrictive practices on and against all people with disability, including non-consensual and coercive sterilisation, contraception, menstrual suppression and abortion. A complement to abolishing laws enabling violence through denial of legal capacity, is to introduce laws that facilitate people with disability exercising their legal capacity through supported decision-making mechanisms, including the right of women and girls with disability to make free, informed and responsible choices about their bodies, sexual health, reproductive health, intimate and emotional relationships, and parenting. Supported decision-making laws must be accompanied by abolition, desegregation and deinstitutionalisation in order to end the systems of incarceration and control that undermine the possibility of exercising autonomy and choice in relation to one's body and life.

- 7.9 Realising sexual and reproductive justice also requires abolition of substituted decision-making laws that deny legal capacity to women and girls with disability in relation to decision-making and participation in court and tribunal proceedings. In its place, governments should introduce supported decision-making in justice systems and provide access to associated supports and resources for people with disability participating in court proceedings. This is a particular issue in some state and territory child protection jurisdictions (as noted in Section 6) and might also apply to women and girls with disability bringing civil litigation to obtain redress for sexual and reproductive violence.
- 7.10 Realising sexual and reproductive justice involves addressing structural barriers to women and girls with disability accessing and engaging justice systems to address and redress sexual and reproductive violence. It is vital to address barriers in criminal justice systems (including police, prosecution and courts) and criminal law and criminal procedure law that situate sexual and reproductive violations outside of criminalised violence and fail to recognise women and girls with disability who experience such violence as victims and witnesses. In a similar vein, laws and processes around gender-based violence also need to be inclusive of and responsive to experiences of women and girls with disability, particularly when these experiences do not align with those of non-disabled women and girls.
- 7.11 It is also important that there is a national inquiry into the legal, policy and social support environment that gives rise to removal of babies and children from parents with disability, at a rate at 10 times higher than non-disabled parents. This is vital to increasing knowledge of the role of parenting services, child protection systems, and legal and justice systems in violence against parents with disability, particularly First Nations parents with disability.
- 7.12 Sexual and reproductive ‘justice’ must not be construed in purely legalistic terms. Achieving ‘justice’ requires transformation of legal and justice systems, and this necessarily involves engaging strategies beyond, alongside or even against some conventional legal and human rights approaches. Our submission has highlighted the structural, historical, and intergenerational nature of sexual and reproductive violence – that it has profound impacts on specific women and girls with disability, and on families and communities, and that these impacts extend back throughout Australia’s history. Redressing, or setting right, this violence must be a core concern of the Royal Commission alongside how to prevent further violence from occurring in the future. Redress must not be dependent on individuals accessing court-based remedies. Instead an entire framework of redress must be designed specifically in relation to sexual and reproductive violence against women and girls with disability and this framework should be co-designed with women with disability and their representative organisations. The framework should be inclusive and accessible and encapsulate an entire suite of individual and structural options, including compensation, rehabilitation and recovery for individual victim-survivors, as well as structural and community-based redress such as apologies, memorialisation and community education.
- 7.13 Sexual and reproductive justice cannot be achieved without significant transformation of the NDIS. Contrary to the popular understanding of the NDIS as facilitating choice and control for people with disability, our submission has shown how the NDIS facilitates human rights violations related to legal capacity, bodily integrity, freedom from violence, community inclusion, privacy, and equality and non-discrimination and ultimately enables sexual and reproductive violence. NDIS laws, rules and practices must be scrutinised for their impacts on sexual and reproductive rights for women and girls with disability. It is necessary to immediately revise the *National Disability Insurance Scheme (NDIS) (Supports for Participants) Rules 2013* (Cth) and related implementation frameworks and strategies to ensure explicit provisions for NDIS participants to access funded supports for parenting and support that enable them to realise their rights to sexual health information, sexual pleasure, expression, association, freedom, autonomy and self-determination, and to

make their own choices about how they regulate (if at all) their menstruation and fertility. NDIS legislation and policies should also be revised to prohibit in NDIS funded services all forms of forced treatment and restrictive practices on and against people with disability, including non-consensual and coercive sterilisation, contraception, menstrual suppression and abortion. At a fundamental level, segregation and violence needs to be removed from the NDIS framework, including NDIS funding and regulation of segregated housing and employment, and 'supports' involving use of restrictive practices.

- 7.14 Sexual and reproductive justice requires access to trauma-informed, inclusive, accessible, physically and culturally safe and empowering services, information, resources and supports related to sexuality and reproduction. Our submission has highlighted that women and girls with disability can experience barriers accessing services, resources and information that can support them to have positive parenting, sexual, and reproductive experiences, and that often the absence or inadequacy of these can give rise to sexual and reproductive violations, such as forced child removal, unlawful gender-based violence and serious health conditions. Services, information, resources and supports must explicitly extend to sexual identity, sexual pleasure, sexual expression and sexual activity, noting the concerns raised in Sections 5 and 6 about the risk of paternalistic, moralistic and medicalistic approaches to sexuality and marginalisation of positive sexual expression and experience in understandings of sexual and reproductive rights.
- 7.15 Lastly, realising sexual and reproductive justice requires comprehensive research and data. As discussed in Section 2, being able to comprehend, understand and respond to sexual and reproductive violence against women and girls with disability depends on research and data that documents the scope and nature of these violations. There is a dearth of research and data on sexual and reproductive violence against women and girls with disability, particularly in relation to the effects, including long-term effects, of non-consensual and coerced sterilisation and LARC, including those in group homes and other forms of institutional care. There is also an absence of research on best and ideal practice in relation to sexual, parenting and reproductive services, resources and information for women and girls with disability. Thus, a comprehensive and ongoing program of research and data collection on sexual and reproductive violence that is co-designed with women and girls with disability and is directed towards realising sexual and reproductive rights is necessary. It is also important to reform longstanding laws and practices concerning lack of access to court and tribunal hearings and decisions in relation to the common law doctrine of *parens patriae* so as to facilitate access to comprehensive and transparent data about judicial and tribunal decision-making enabling sexual and reproductive violence.



APPENDIX 1:

APPENDIX 1: RELEVANT CONCLUDING COMMENTS FROM UN TREATY BODIES

This section of the Submission is taken from the 2019 publication: 'Disabled People's Organisations Australia and the National Women's Alliances, The Status of Women and Girls with Disability in Australia, Position Statement to the Commission on the Status of Women (CSW) Twenty-Fifth Anniversary of the Fourth World Conference on Women and the Beijing Declaration and Platform for Action 1995.' Women With Disabilities Australia, 2019. Written by Carolyn Frohmader for and on behalf of WWDA and DPO Australia. Available at: <https://wwda.org.au/wp-content/uploads/2020/06/The-Status-of-Women-and-Girls-with-Disability-Asustralia.pdf>

The UN has made numerous recommendations, called concluding comments or concluding observations following periodic reviews of Australia under different treaty bodies. The following provides a summary of the most recent key recommendations from these treaty bodies that are relevant to sexual and reproductive rights.

Equality, Non-Discrimination and Participation

In its 2019 Concluding Observations, the **Committee on the Rights of Persons with Disabilities** expressed and reiterated a number of concerns from its 2013 initial review of Australia: the lack of an effective legislative framework to protect people with disability from systemic, intersectional and multiple forms of discrimination; a lack of an effective monitoring mechanism and insufficient resources to effectively implement the National Disability Strategy; limited opportunities for women and girls with disability to participate in the development of policies regarding the rights of women and gender equality; and the lack of nationally consistent measures for the collection and public reporting of disaggregated data on the full range of obligations contained in the Convention. The Committee recommended that Australia: enact a comprehensive national human rights law; strengthen anti-discrimination laws to address and prohibit systemic, intersectional and multiple forms of discrimination; provide sufficient resources and establish a formal monitoring mechanism for the National Disability Strategy; and develop a national disability data framework to ensure nationally consistent measures for the collection and public reporting of disaggregated data on the full range of obligations contained in the Convention, especially with regard to women, children and Indigenous persons with disabilities. The Committee further recommended that Australia strengthen measures to address multiple and intersectional forms of discrimination against women and girls with disability and, in particular, adequately support organisations and networks of women and girls with disability, particularly those representing Indigenous women and girls with disability, to engage in all initiatives to promote gender equality and ensure their effective participation in the development of policies for gender equality and the advancement of women and girls.

The **Committee on the Elimination of Discrimination against Women** reviewed Australia's implementation of CEDAW⁹⁷⁰ in 2018.⁹⁷¹ The Committee expressed its concern at the lack of harmonisation of anti-discrimination legislation, and the absence of a Charter of Human Rights that guarantees equality between women and men or a general prohibition of discrimination against women. Amongst other things, the Committee recommended that Australia harmonise federal, state and territory legislation against discrimination in line with the Convention; and fully incorporate the Convention into national law by adopting a Charter of Human Rights that includes a guarantee of equality between women and men and prohibits discrimination against women. The Committee further recommended that Australia adopt a comprehensive national gender equality policy with performance indicators and ensure sufficient human and financial resources to coordinate and monitor the implementation of that policy.

In 2019, the **Committee on the Rights of the Child** provided its Concluding Observations⁹⁷² to

Australia following its review. The Committee recommended that Australia: enact comprehensive national child rights legislation fully incorporating the Convention and providing clear guidelines for its consistent and direct application throughout Australia; ensure adequate resources for the Parliamentary Joint Committee on Human Rights to effectively examine all proposed legislation and its impact on children's rights; ensure that the National Children's Commissioner has adequate and sufficient human, technical and financial resources to implement and monitor the application of the Convention; and establish by law mandatory consultations between the National Children's Commissioner and children on issues that affect them and ensure that the results of those consultations and any other recommendations made by the Commissioner are taken into consideration in law and policymaking. The Committee also recommended that Australia adopt a national comprehensive policy and strategy on children that encompasses all areas of the Convention, with sufficient human, technical and financial resources for its implementation; establish appropriate mechanisms and inclusive processes so that civil society, the community and children specifically may participate in all stages of the budget process, including formulation, implementation and evaluation; and ensure that data collected on children's rights cover all areas of the Convention, in particular those relating to violence, alternative care, natural disasters and children in conflict with the law, that they are disaggregated by age, sex, disability, geographic location, ethnic origin, national origin and socioeconomic background, and that they identify children in situations of vulnerability, such as Indigenous children, children with disability and asylum-seeking, refugee and migrant children.

In its 2017 Concluding Observations⁹⁷³ on the fifth periodic report of Australia,⁹⁷⁴ the **Committee on Economic, Social and Cultural Rights** expressed its concern that women continue to experience disadvantages across key areas (including work, health, education, and housing) and recommended that Australia intensify its efforts to address the obstacles to achieving substantive equality between men and women, including through the strengthening of temporary special measures. The Committee also recommended that Australia consider introducing a federal Charter of Rights that guarantees the full range of economic, social and cultural rights. In relation to the *National Disability Strategy 2010-2020*, the Committee expressed its concern at the slow progress in its implementation and its weak accountability and implementation mechanisms. The Committee recommended that Australia ensure full implementation of the National Disability Strategy by focusing on all the six areas covered and allocating the necessary resources. The Committee further recommended that Australia strengthen accountability mechanisms to ensure that people with disability fully enjoy their economic, social and cultural rights.

In its 2017 Concluding Observations⁹⁷⁵ on the sixth periodic report of Australia under the **International Covenant on Civil and Political Rights**,⁹⁷⁶ the Human Rights Committee recommended that Australia should take measures, including considering consolidating existing non-discrimination provisions in a comprehensive federal law, in order to ensure adequate and effective substantive and procedural protection against all forms of discrimination on all the prohibited grounds, including religion, and intersectional discrimination, as well as access to effective and appropriate remedies for all victims of discrimination.

Freedom from Violence, Abuse, Neglect and Exploitation

In September 2019, the **Committee on the Rights of Persons with Disabilities** adopted its Concluding Observations following its review of Australia's compliance with the Convention on the Rights of Persons with Disabilities.⁹⁷⁷ The Committee expressed concern about: the lack of oversight, complaint and redress mechanisms for people who are not eligible for the NDIS and who experience violence, particularly women with disability; the lack of resources and redress mechanisms available for people with disability to participate in the Royal Commission into Violence, Abuse, Neglect and Exploitation of Persons with Disabilities; the non-implementation of recommendations in the report from the Australian Human Rights Commission (AHRC), 'A Future

without Violence’; the lack of explicit reference to women and girls with disability in the National Plan to Reduce Violence against Women and their Children 2010-2020; the insufficient expertise and structural barriers within services dealing with domestic violence, sexual assault and related crises to adequately support women and girls with disability; and the limited number and scope of instruments to collect data on violence against women and girls with disability. The Committee recommended that Australia: establish a national accessible oversight, complaint and redress mechanism for all people with disability in all settings, particularly older women with disability; ensure adequate resources and a redress mechanism for the Royal Commission; implement the recommendations contained in the AHRC report; ensure inclusion of women and girls with disability in the National Plan; ensure accessible gender and age sensitive services that are inclusive of women and girls with disability; and address the methodological restrictions in data collection instruments used to capture data on violence against women and girls with disability.

In its 2018 review⁹⁷⁸ of Australia’s eighth periodic report⁹⁷⁹ under the **Convention on the Elimination of All Forms of Discrimination Against Women**, the CEDAW Committee expressed its concern at the lack of national legislation prohibiting all forms of gender-based violence against women. The CEDAW Committee recommended that the Australian Government adopt Commonwealth legislation that is in line with the Convention and prohibits all forms of gender-based violence against women and girls and shift the power to legislate on this matter to the Commonwealth Parliament. The Committee also recommended that Australia should expedite the establishment of the national data collection framework and guarantee that data on femicide and violence against women with disability is systematically collected under the framework.

In its 2019 Concluding Observations⁹⁸⁰ of Australia, the **Committee on the Rights of the Child** expressed its serious concerns about the high rates of violence against children in the home, that girls between the ages of 10-19 years suffer the highest rate of sexual abuse, that Indigenous children continue to be disproportionately affected by family and domestic violence, including sexual violence, that children with disability are more vulnerable to violence, neglect and abuse, including sexual abuse, and that girls with disability are forced to undergo sterilisation procedures. The Committee recommended that Australia: prioritise implementation of violence prevention and response measures for children, particularly girls, of all ages within the National Framework for Protecting Australia’s Children 2009-2020 (National Framework) and the National Plan to Reduce Violence against Women and their Children 2010–2022 (National Plan); ensure that the National Centre for the Prevention of Child Sexual Abuse establishes a comprehensive standard with regard to intervention in cases of child sexual abuse to avoid the re-traumatisation of child victims; provide child-specific therapeutic interventions and counselling to child victims of violence, in addition to the support provided to families; substantially increase family violence prevention and responses related to Indigenous children; review the National Framework and the National Plan to ensure they adequately prevent violence against children with disability and prohibit by law forced or coerced sterilisation of girls with disability; and enact legislation to prohibit unnecessary medical or surgical treatment on intersex children and provide support and counselling to families of intersex children.

In its 2017 Concluding Observations⁹⁸¹ on the fifth periodic report of Australia,⁹⁸² the **Committee on Economic, Social and Cultural Rights** expressed its concern about the high levels of violence and abuse against persons with disability, especially those with intellectual disability and women with disability, placed in institutions or residences. The Committee also articulated its concern at the lack of effectiveness of oversight and complaint mechanisms in alternative care settings. The Committee recommended amongst other things, that Australia redouble its efforts to combat domestic violence against women and children, including among Indigenous peoples; increase accommodation and support services, especially in rural and remote areas; fully implement the recommendations in the inquiry report by the Senate Community Affairs References Committee into violence, abuse and neglect against people with disability in institutional and residential settings (2015); and pay particular attention to ensure that women with disability who are victims of domestic violence can claim their rights.

In 2017, the Human Rights Committee released its Concluding Observations⁹⁸³ on the sixth periodic report of Australia under the **International Covenant on Civil and Political Rights**.⁹⁸⁴ While welcoming the various measures taken to address violence against women, the Committee specifically noted its concern that violence against women in Australia continues to have a disproportionate effect on women with disability and Indigenous women. In relation to violence against women with disability, the Committee recommended that Australia improve support services to women with disability who are victims of domestic violence, including through the implementation of the relevant recommendations from the Stop the Violence Project.⁹⁸⁵ The Committee also recommended that all allegations of sexual abuse, regardless of the time of their commission, are promptly, impartially, thoroughly and effectively investigated and perpetrators are brought to justice and, if found responsible, are punished in accordance with the gravity of their acts.

The **Committee against Torture** reviewed the combined fourth and fifth periodic reports of Australia⁹⁸⁶ in 2014. The Concluding Observations⁹⁸⁷ from the review noted the Committee's concern that violence against women in Australia disproportionately affects women with disability and Indigenous women. The Committee recommended amongst other things that Australia redouble its efforts to prevent and combat all forms of violence against women and increase its efforts to address violence against women with disability and Indigenous women.

Health

In 2019, the **Committee on the Rights of Persons with Disabilities** provided its Concluding Observations⁹⁸⁸ on the combined second and third periodic report of Australia.⁹⁸⁹ The Committee expressed concern about: the significantly lower life expectancy of people with disability; the significant number of people with disability expressing suicidal ideation, particularly within Indigenous communities; the high rate of premature, unexpected and avoidable deaths among people with disability in care settings; the significantly poorer health status of people with disability; and the limited access to adequate, affordable and accessible health services and equipment, in particular for women and children with disability, Indigenous peoples with disability, people with disability living in institutions and in remote areas, and those with intellectual or psychosocial disability. The Committee also expressed its concern that: parents with disability are more likely to have their children removed from their care on the basis of disability; the lack of support to parents with disability to exercise parental responsibilities; and the discrimination experienced by women with disability, lesbian, gay, bisexual, transgender, intersex and queer (LGBTIQ) persons with disability in accessing assisted reproductive technologies. Further, the Committee expressed concern about: the medical model assessment to determine eligibility for the National Disability Insurance Scheme (NDIS); the lack of equal opportunities in the NDIS particularly for older persons with disability, Indigenous peoples with disability, people with disability from culturally and linguistically diverse backgrounds and people with intellectual or psychosocial disability; and the low percentage of women and girls with disability that have access to services under the NDIS. The Committee recommended that Australia: address the low life expectancy of people with disability; ensure that national mental health and suicide prevention plans include measures for people with disability; develop culturally appropriate measures to prevent, identify and address the high rate of suicide among Indigenous populations; ensure training of professionals working with people with disability including health, social, education and community workers; ensure equitable access to affordable, accessible, quality and culturally sensitive medical equipment and health services, including sexual, reproductive and mental health services; ensure that the free and informed consent of the person concerned is provided prior to any medical treatment; and that health care practitioners receive training on the human rights model of disability. The Committee also recommended that Australia: ensure that no child is separated from parents because of the disability of one or both parents; adopt comprehensive

gender and culturally specific parenting and family support measures for parents with disability; and that women with disability and LGBTIQ people with disability have equal access to assisted reproductive technologies. Further, the Committee recommended that: the NDIS be aligned with the human rights model of disability; there is equal access to services under the NDIS for women and girls with disability, particularly those of Indigenous backgrounds; NDIS procedures are simplified, transparent, publicly available and accessible; the NDIS meets the diverse and intersecting requirements of persons with disability in all areas; and provide adequate support and equal opportunities to specific groups of people with disability who are disadvantaged or not eligible for the NDIS.

In its 2018 review⁹⁹⁰ of Australia's eighth periodic report⁹⁹¹ under the Convention on the Elimination of All Forms of Discrimination Against Women, the **CEDAW Committee** recommended that Australia increase its efforts and resources to address the deteriorating mental health situation of women and girls, in particular young mothers, Indigenous women, women with disability, women in detention, migrant women and their daughters, lesbian, bisexual and transgender women and intersex persons, and reinforce preventive measures. The Committee also recommended that Australia allocate sufficient funding to the National Disability Insurance Scheme (NDIS) to extend coverage for mental health services to women and girls with all types of mental health conditions and disabilities. The Committee further recommended that Australia finalise the national strategic framework for the mental health and social and emotional well-being of Indigenous peoples, guarantee appropriate resources for its implementation and address intergenerational trauma in culturally appropriate and effective ways. In relation to refugee and asylum-seeking women and girls, the Committee recommended that Australia ensure they have access to comprehensive, adequate and accessible sexual and reproductive health services and information, including to emergency contraception and abortion services.

In its 2019 Concluding Observations⁹⁹² of Australia, the **Committee on the Rights of the Child** expressed its serious concern about the increase in numbers of children with mental health problems, that suicide is the leading cause of death among those aged 15-24, children under 14 years of age have limited access to mental health services, and the limited child-specific measures in the Fifth National Mental Health and Suicide Prevention Plan. The Committee also expressed concern that Australia has one of the highest rates of children aged 5-14 years diagnosed with attention deficit hyperactivity disorder (ADHD) with a dramatic increase in the number of psychostimulant drug prescriptions. The Committee recommended that Australia: invest in the underlying causes of suicide and poor mental health among children; ensure that the Fifth National Mental Health and Suicide Prevention Plan includes a clear focus on children; that mental health service delivery to children in vulnerable situations, including children with disability, is prioritised; strengthen measures to ensure that psychostimulant drugs are only prescribed to children with ADHD as a last resort and only after an individualised assessment of the child's best interests; inform children with ADHD and their parents about the side effects of psychostimulant drugs and about non-medical alternatives; increase the availability of child-friendly mental health services including to children under 14 years. The Committee also recommended that Australia promptly address the disparities in health status for children with disability, Indigenous children, children living in remote or rural areas and children in alternative care; to strengthen measures to prevent teenage pregnancies among Indigenous girls; and to continue to provide sexual and reproductive health as part of the mandatory school curriculum. In its 2017 Concluding Observations⁹⁹³ on the fifth periodic report of Australia,⁹⁹⁴ the Committee on Economic, Social and Cultural Rights expressed its concern at the poor health status of Indigenous peoples, refugees and asylum seekers. The Committee recommended that Australia redouble its efforts to achieve the health targets outlined in the Closing the Gap strategy and take effective steps to ensure refugees and asylum seekers are able to exercise their right to the highest attainable standard of health, with particular attention to mental health services. The Committee articulated its extreme concern with regard to the negative impact on mental health of the prolonged detention of children in the regional processing centres and recommended that Australia ensure access to appropriate child and family psychiatric care by asylum seekers and support for their social integration.

In 2017, the **Human Rights Committee** released its Concluding Observations⁹⁹⁵ on the sixth periodic report of Australia under the International Covenant on Civil and Political Rights.⁹⁹⁶ The Committee recommended that Australia address the conditions of detention in immigration facilities, provide adequate mental health care, refrain from applying force or physical restraints against migrants and ensure that all allegations of use of force against them are promptly investigated, that perpetrators are prosecuted and, if convicted, punished with appropriate sanctions, and that victims are offered reparation. In December 2017, the Committee on the Elimination of Racial Discrimination released its Concluding Observations⁹⁹⁷ of Australia's compliance under the International Convention on the Elimination of All Forms of Racial Discrimination. The Committee expressed its concern at the high rate of suicide among Indigenous peoples, and the lack of specific programmes for Indigenous peoples with disability. The Committee recommended, amongst other things, that Australia adopt and implement other adequately resourced programmes, including specific programmes for Indigenous peoples with disability, in consultation with them, and increase support for, and investment in, Indigenous community- controlled health services and programmes. The Committee further recommended that Australia collect data disaggregated by ethnicity, Indigenous peoples, age, gender, disability, sexual orientation and gender identity, on the extent of suicide and report on the measures adopted to address it.

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APPENDIX 2: ENDNOTES

APPENDIX 2: ENDNOTES

- 1 Committee on the Rights of Persons with Disabilities, *General Comment No. 7 on the Participation of Persons with Disabilities, Including Children with Disabilities, through Their Representative Organizations, in the Implementing and Monitoring of the Convention*, UN Doc CRPD/C/GC/7 (9 November 2018).
- 2 Disabled People’s Organisations Australia, *Segregation of People with Disability Is Discrimination and Must End* (Position Statement, September 2020).
- 3 See: <https://lookingglass.org/>
- 4 Women With Disabilities Australia, *Sexual and Reproductive Rights* (WWDA Position State No 4, September 2016) 4.
- 5 ‘Forced sterilization’ refers to the performance of a procedure which results in sterilization in the absence of the prior, free and informed consent of the individual who undergoes the procedure, including instances in which sterilization has been authorized by a third party, without that individual’s consent. This is considered to have occurred if the procedure is carried out in circumstances other than where there is a serious threat to life. Coerced sterilization occurs when financial or other incentives, misinformation, misrepresentation, undue influences, pressure, and/or intimidation tactics are used to compel an individual to undergo the procedure. Coercion includes conditions of duress such as fatigue or stress. Undue influences include situations in which the person concerned perceives there may be an unpleasant consequence associated with refusal of consent. Any sterilization of a child, unless performed as a life-saving measure, is considered a forced sterilization. See for example: Center for Reproductive Rights (2010). *Reproductive Rights Violations as Torture and Cruel, Inhuman, or Degrading Treatment or Punishment: A Critical Human Rights Analysis*; Center for Reproductive Rights, New York. See also: Juan E. Mendez, Special Rapporteur, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, 22nd session, UN Doc A/HRC/22/53; See also: Manjoo, R. (2012) Report of the Special Rapporteur on violence against women, its causes and consequences. United Nations General Assembly, UN Doc No. A/67/227; See also: Nair, P. (2011) Litigating Against Forced Sterilization of HIV-Positive Women: Recent Developments in Chile and Namibia. *Harvard Human Rights Journal*, Vol.23, pp.223-231. See also: Frohmader, C. (2013) ‘Dehumanised: The Forced Sterilisation of Women and Girls with Disabilities in Australia’. WWDA Submission to the Senate Inquiry into the involuntary or coerced sterilisation of people with disabilities in Australia. Prepared for Women with Disabilities Australia (WWDA), Tasmania. ISBN: 978-0-9876035-0-0.
- 6 Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (Final Report No 1, 17 July 2013) 31.
- 7 Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (Final Report No 1, 17 July 2013) ix.
- 8 Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (Final Report No 1, 17 July 2013) x.
- 9 Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (Final Report No 1, 17 July 2013) ix–x.
- 10 Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (Final Report No 1, 17 July 2013) x.
- 11 Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (Final Report No 1, 17 July 2013) ix.
- 12 Senate Community Affairs References Committee, Parliament of Australia, *Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (Final Report No 1, 17 July 2013) 169.
- 13 Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia, Adopted by the Committee at Its Tenth Session (2-13 September 2013)*, CRPD/C/AUS/CO/1, 21 October 2013, 5[39].
- 14 Committee on the Rights of Persons with Disabilities, *Concluding Observations on the Initial Report of Australia, Adopted by the Committee at Its Tenth Session (2-13 September 2013)*, CRPD/C/AUS/CO/1, 21 October 2013, 6[40].

- 15 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws: Final Report*, (Report 124, August 2014).
- 16 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws: Final Report*, (Report 124, August 2014) 99–119.
- 17 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws: Final Report*, (Report 124, August 2014) 28.
- 18 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws: Final Report*, (Report 124, August 2014) 28.
- 19 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws: Final Report*, (Report 124, August 2014) 244; Department of Social Services, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (Report, 1 May 2013).
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“best interest” of the person concerned. Nevertheless, to the extent that they inflict severe pain and suffering, they violate the absolute prohibition of torture and cruel, inhuman and degrading treatment.” See: Juan E. Mendez, *Opcit.*, para 64. In addition, the UN Special Rapporteur on Torture also stated that “hormone therapy and genital-normalizing surgeries under the guise of so called ‘reparative therapies’... are rarely medically necessary, can cause scarring, loss of sexual sensation, pain, incontinence and lifelong depression and have also been criticized as being unscientific, potentially harmful and contributing to stigma.” See: Juan E. Mendez, *Op. Cit.*, para 76.

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- I reject the proposition that sexual rights are human rights. From a legal point of view references to human rights should be confined to those identified in treaties or local legislation, and I would understand the Convention on the Rights of Persons with Disabilities in its reference to human rights as not referring to sexual rights.
- That raises the question whether a “fundamental freedom” is involved in the facts of the case. That is a question which may be arguable both ways, and I would hesitate to reach a firm view about the question, since the matter was not fully argued and I was referred to no learning about it.’: *WRMF v National Disability Insurance Agency* [2019] AATA 1771, [19]–[21].
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Awards

Winner

National Human Rights Award 2001

Winner

National Violence Prevention Award 1999

Winner

Tasmanian Women's Safety Award 2008

Nominee

UNESCO Prize for Digital Empowerment of Persons with Disabilities
2021

Nominee

French Republic's Human Rights Prize 2003

Nominee

UN Millennium Peace Prize for Women 2000

Certificate of Merit

Australian Crime & Violence Prevention Awards 2008

Nominee

National Disability Awards 2017